North Carolina Systemic, Therapeutic, Assessment, Respite and Treatment program (NC START) Annual Report

April 2010

NC START West, East and Central Teams

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North Carolina Systemic, Therapeutic, Assessment, Respite, and Treatment program (NC START)

Introduction

The prevalence in the US of persons with intellectual/developmental disability and a co-occurring mental illness is estimated to be 3,063,804. Studies show that people who have a dual diagnosis of mental illness and intellectual/ developmental disability are at greater risk for institutionalization than people diagnosed with an intellectual/ developmental disability alone. In addition, overuse of community emergency departments and long stays in psychiatric facilities has been documented in this population.

There is also empirical evidence that people with co-occurring mental illness and intellectual/developmental disability (MI/DD) are more likely to use emergency mental health services and psychiatric inpatient services than other forms of community mental health care. Experts have attributed these outcomes to a lack of coordination across professional disciplines and a lack of expertise treating this population amongst community mental health practitioners.

As with many populations that require the use of multiple services and systems of care, there are gaps in the service system that undermine the ability to provide successful support. The need for close collaboration between general mental health services and specialized services is a necessary component of community support for this population.

Other gaps in the community system have been found to include lack of community based crisis supports (particularly crisis beds), need for specialized training for support staff, and lack of collaboration between systems of care at the community level. Traditional mental health services in the community have been shown to be too fragmented, inaccessible, and ineffective as a treatment option for many individuals with intellectual/developmental disabilities. For these individuals, what is needed is a highly coordinated, multimodal approach to assessment and treatment which is coordinated by a team member who is able to understand and integrate different strands of information.

Advocates have long supported both structural and strategic remedies to create positive long-term changes in the system and a number of model programs were developed in response. START (an acronym for Systemic, Therapeutic, Assessment, Respite and Treatment) is a model first established in 1989 to help coordinate care for individuals with dual diagnoses of ID/MI.

The original START program was cited in the 2002 Surgeon General's report as a model to help overcome disparities in access to effective mental health care for persons with intellectual/developmental disabilities. Outcomes associated with prior applications of the model have been promising in overcoming disparities cited in the report (A Report of the Surgeon General's Conference on Health Disparities and Mental Retardation, 2002). These include significant reduction in emergency service use, increases over time in planned supports/service use, and satisfaction with service experiences for individuals and their families.

In a comparative analysis of the TN -START demonstration project in Chattanooga Tennessee conducted in 2007, findings included significant cost savings when compared to individuals who did not receive services through the TN -START program in Tennessee. The underlying philosophy of the START model is that services will be most effective when everyone involved in care and treatment is allowed to participate actively in treatment planning and service decisions. In order for this to occur, collaboration between service providers and with service users is needed.

NC-START was initiated in 2009 and is a service linkage crisis prevention and intervention program designed to improve services to this population of service users in North Carolina. Individuals receive a comprehensive multi-modal assessment from the START team (a qualified professional, psychologist, and psychiatrist), to assist the individual's system of care to improve service outcomes. In addition, outreach and communication are central to our services. For example, a START team member typically accompanies the individual to medical appointments to support communication and share information, and to open up a channel for communication between providers, service users and experts available through the START teams.

The goal of NC-START is to enhance the existing system of care, to provide technical support and assistance and to fill in service gaps. Emergency and planned clinical respite are included in the services provided to meet this important goal.

Background

Based on recent published articles, it is estimated that approximately 25% of individuals with ID/DD may also have co-occurring MI and/or behavioral health needs. Therefore in North Carolina, as many as 35,000 people may have a dual diagnosis.

In fiscal year 2008, there were a total of 1,028 admissions to state psychiatric hospitals for individuals with developmental disabilities. In response to the need to improve community based services, discussions began at the state level to identify and fund a solution. The Developmental Disabilities Practice Improvement Collaborative (DD-PIC) identified START as a viable option to address the increased state psychiatric hospital admissions for individuals with intellectual and developmental disabilities.

The DD-PIC provided their recommendation for bringing the START model to North Carolina to the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (referred to as The Division) (North Carolina's State Behavioral Health Authority). This recommendation was presented to the North Carolina Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities and Substance Abuse Services and funds were appropriated for creation of the North Carolina START program in 2008.

During state fiscal year 2009 persons seen in community hospital emergency departments in North Carolina include 26,979 individuals with a developmental disability diagnoses. When only those individuals with a developmental disability as the 'primary' diagnosis are included, there were 2,844 individuals with developmental disabilities diagnoses seen in local community hospital emergency departments during this time.

To assist with implementation of the NC START program, the Division contracted with Dr. Joan Beasley (creator of the START model) to train providers and Local Management Entities (LME's) on the START model. Following this training, three providers and three LME's were selected to implement the START model.

NC-START Implementation

In North Carolina, NC- START has been implemented across the state through three regionally based START teams. The Lead LME is responsible for managing the state-appropriated START funds through contracting with the private provider designated by the Division of MH/DD/SA.

The Regional NC-START Teams are listed below:

Team	LME	Provider Agency
NC-START West	Western Highlands	RHA
NC-START Central	The Durham Center	Easter Seals UCP
NC-START East	ECBH	RHA

While there are several entities involved in NC-START, there has been an intentional effort to maintain consistency across the state. Through regularly scheduled consultation with Dr. Beasley, the three regions have worked together to develop consistent policies and processes. Collection of data is also standardized. The Division of MH/DD/SA has been actively involved through all stages of implementation and will continue to monitor through collection of data and on-going contact with the regional teams.

The Mission of NC START

The Mission of NC-START is to enhance local capacity and provide collaborative cost-effective support to individuals and their families through exemplary clinical services, education and training, with close attention to service outcomes.

In meeting the mission of NC-START the goals for the first year of implementation were to:

1. Provide support and technical assistance to Mobile Crisis Teams
2. Access and develop expertise needed to provide effective supports and services
3. Create and maintain linkages and relationships with community partners
4. Coordinate support meetings and cross systems crisis plans for individuals
5. Provide on-going consultation to providers and/or families
6. Provide training and technical assistance to community partners
7. Provide short-term respite – both emergency and planned

8. Identify partners and develop linkages to help fill in service gaps as needed

9. To assess the needs of the population statewide and to work with stakeholders to insure that effective service delivery takes place.

Referral Sources and Eligibility Requirements

NC-START receives referrals through many and varied channels. Our primary referral source is an individual's clinical home provider (e.g. targeted case management, community support team). Referrals also come from LME's Mobile Crisis Management Teams, Inpatient Units, Developmental Centers and State Psychiatric Hospitals. Referrals most often are made by residential provider agencies along with hospital emergency departments. At times, physicians and family members also make referrals.

All of the individuals referred to NC -START have a developmental disability. Individuals with a developmental disability (eligible for NC START) meet the following criteria:

"Developmental disability" means a severe, chronic disability of a person which:

a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;

b. Is manifested before the person attains age 22,

c. Is likely to continue indefinitely;

d. Results in substantial functional limitations in three or ore of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and

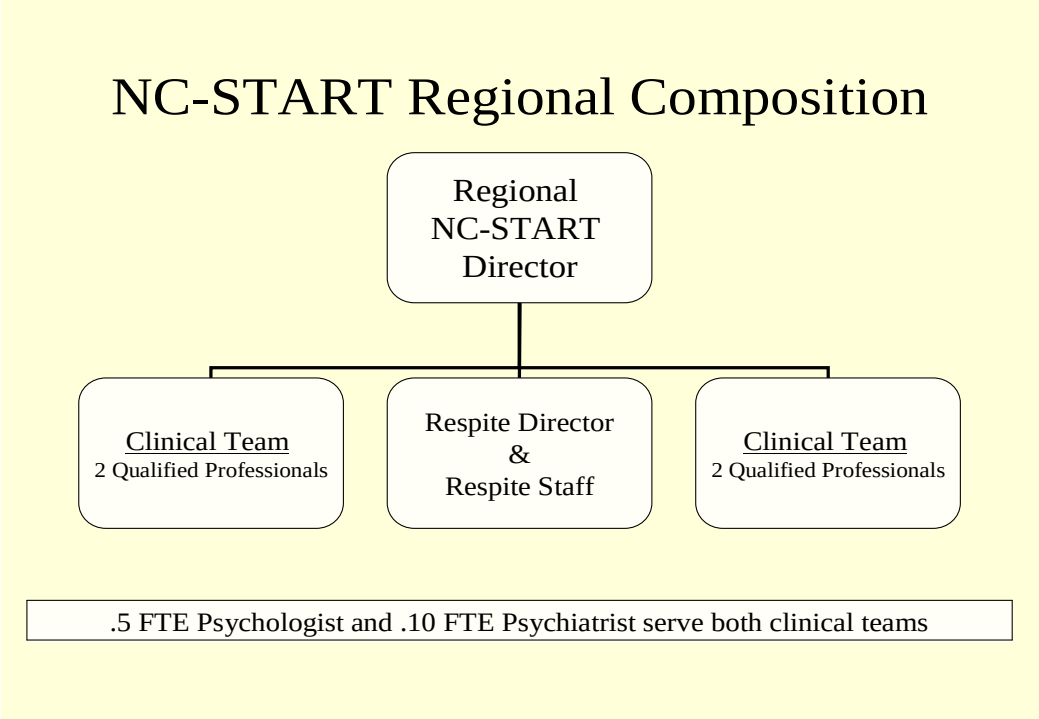
e. Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or

f. When applied to children from birth through four years of age, may be evidenced as a developmental delay.

Individuals referred to NC START must be at least 18 years of age. It is expected that clients also have a diagnosis of mental illness and/or behavioral challenges.

Structure of the Regional NC-START Teams

In North Carolina, each region has a START Director who supervises two START Teams and a Respite Facility with 4-bed capacity. The NC-START team is outlined in the following organizational chart. Critical in the development and implementation of the NC-START program is the Advisory Council. It consists of stakeholders, experts, and personnel from NC-START. The members are listed in Appendix 1. The Advisory Council meets quarterly to provide support and review progress and future directions. The Advisory Council enhances our capacity to remain accountable to everyone involved.



The NC-START teams offer both clinical team and respite services described in greater detail in the pages that follow.

NC-START Clinical Team Services

Each NC-START team includes local experts to enhance our ability to meet our goals. The NC-START Clinical Director is a Psychologist responsible for providing consultation and training to Team Clinicians through weekly clinical team meetings, coordinating monthly Cross Systems Clinical Team

Meetings, providing consultation to community psychologists and other providers in the system, identifying community resources, providing training and technical assistance to community partners and assessments for individuals while at START respite.

The NC-START Medical Director is a Psychiatrist responsible for consultation to Team Clinicians, evaluations to guests at NC-START respite and consultation and training to psychiatrists in the community.

NC-START Team services

NC-START develops relationships with community partners in order to bridge service gaps and improve service outcomes. This includes development of affiliation agreements.

Collaborative contacts are made up of crisis prevention planning meetings, consultation visits, treatment planning meetings, and follow-up meetings. START clinicians are required to facilitate individual crisis prevention planning meeting at least once a year. Whenever possible, the NC-START clinician, the service user, members of the mental health service team (i.e., the outpatient therapist, a representative from the mental health crisis team, the psychiatrist), members of the D/ID service team, and the individual's informal or social supports (family members, friends, and other interested parties) meet to develop a plan to assist the individual and his or her caregivers during times of difficulty.

Cross-Systems Crisis Prevention and Intervention Planning (CSCP)

NC START clinicians facilitate individual Cross-Systems Crisis Prevention and Intervention Planning (CSCP) meetings at least once a year. Whenever possible, the NC -START QP, the individual, members of the mental health service team (which could include: an outpatient therapist, a representative from the clinical home provider, psychosocial rehabilitation provider, etc.), members of the developmental disabilities service team (which could include: the targeted case manager, residential and day program providers), and the individual's natural supports (family members, friends, and other interested parties) meet to develop a plan to assist the individual and his or her caregivers during times of difficulty.

NC -START QPs maintain on-going contact with family members and other caregivers. Follow-up meetings are scheduled to evaluate the effects of treatment strategies, update crisis prevention plans and to foster active communication among providers and with direct caregivers.

The first and perhaps most important way to handle a crisis is to avoid its occurrence whenever possible. Crisis service use most often follows severe maladaptive behaviors on the part of the individual, e.g., assault or property destruction. Crisis prevention planning can provide a strategy to assist an individual and the people who provide support to better cope in times of difficulty. There are four goals of the CSCP process to accomplish this task:

(1) *Reaching an understanding regarding communication of needs through maladaptive behaviors.* A primary goal of the collaborative planning process is for all concerned parties to reach consensus regarding what an individual may be communicating through maladaptive behaviors. Family caregivers and other people providing support and assistance can better introduce alternative strategies to help an individual get their needs and wishes met when they understand the "meaning" of a given maladaptive behavior. When effective, this strategy helps to prevent a crisis from occurring.

2) *Developing/improving upon coping strategies for the individual and caregiver*. The CSCP outlines options for individuals and their caregivers to cope with feelings or difficulties that may increase the likelihood of maladaptive behavior(s) if not addressed. For example, the plan may delineate "early warning signs" that may indicate an individual is experiencing anxiety. Based on what is known about the individual, the plan outlines relaxation techniques to assist in reducing the person's anxiety.

3) *Preventing the system from going into crisis.* The roles and responsibilities for specific professionals and service providers are delineated. The CSCP helps service providers respond more effectively in times of crisis. It is helpful when the plan is as specific as possible in defining who should be contacted and when. The plan may also include important facts about the individual to help service providers contacted to better assist the caregivers. To ensure that the plan is taken seriously, each plan is signed and approved by all involved parties.

4) *Simplify access to services.* It is important that access to emergency services be as easy as possible. For example, we provide a list of services and important contacts to families and caregivers. Families and other direct support providers have ready access to the list as part of the CSCP.

See Attachments for a CSCP template.

START clinicians also maintain on-going contact with family members and other caregivers. Follow-up meetings are scheduled to evaluate the effects of treatment strategies, update crisis prevention plans and to foster active communication amongst providers and with direct caregivers.

In addition, NC-START provides 24-hour on site crisis assistance whenever possible in collaboration with local Mobile Crisis teams and First responders to assist in times of crisis. After hours (5:00 P.M.- 9:00 A.M. Monday through Friday and all weekend), NC-START clinicians rotate on-call responsibilities and are available to provide assistance 24 hours a day, 7 days a week. Crisis contacts may be phone calls made after hours to assist during a time of crisis. In addition, clinicians may provide mobile evaluation services and assist a mental health crisis team to determine whether or not a psychiatric inpatient admission is needed, to locate an available inpatient bed, or to pre-screen the individual for an emergency respite admission.

Emergency meetings are team meetings facilitated by NC-START clinicians on a psychiatric inpatient unit or at NC-START respite facility following an admission. The meetings are scheduled within 24 hours of the admission or the next business day whenever possible. The purpose of the meeting is to allow the NC-START clinician and other members of the team to provide information to the inpatient unit in order to assist with treatment and disposition planning. Family members and residential providers are strongly encouraged to participate in the meeting.

In addition, the NC-START clinician attempts to facilitate phone contact between the individual's outpatient and inpatient psychiatrists, and encourages on-going contact between the family and residential provider throughout the admission. Whenever possible, a discharge-planning meeting is also scheduled to ensure a smooth transition back home.

Outreach is an essential part of the NC -START clinical team services. We know from prior research in the context of START that the most overwhelmed systems will not always have the resources to contact us, so that clinicians will check in on a regular basis and visit people to assess how things are going to ensure services and supports are appropriate and timely.

NC -START Respite Services

NC-START respite is a community-based home where people can stay for short periods of time when they are in distress or in need of support and assistance. NC- START respite facilities are staffed with a full-time Director, well-trained direct support professionals, and awake overnight staff. One to one staffing is provided as needed. For the most part, "guests" at the respite center have private bedrooms.

An important goal of the NC-START Respite Centers is to offer a therapeutic environment with adequate space and common areas so that those individuals who have more severe difficulties do not disturb or become disturbed by other guests. Programming is highly structured and assessments provided (see attached schedules and admission/discharge summary form).

All NC-START respite services are affiliated with each other so that if a bed is needed it can be accessed in another region when available.

The essential components of NC-START respite include:

- Crisis Prevention and intervention
- Active collaboration with system of care
- Positive meaningful experiences
- Reduction in caregiver burden
- Family support and education
- Evaluation and treatment

Emergency Respite Stays

Each respite center contains two designated emergency respite beds, for a total of six emergency respite beds state wide. All NC-START service recipients can access emergency respite as needed. Emergency respite is designed to provide out of home housing and services to individuals who for a short period of time (suggested thirty days or less) cannot be managed at home or their residential program.

Once a referral is accepted, NC -START facilitates admission and works with any discharging institutions (e.g., when a person is coming from an inpatient setting) during transition. Whether an admission is emergency or planned, NC -START provides Cross-Systems Prevention and Intervention Services for each guest. NC -START.

The NC -START clinical team provides assistance to the respite program and system of care with discharge planning, which begins as soon as a person enters the respite home. The NC-START team provides training to families and/or support staff and other members of the individual's System of Care on the Cross Systems Crisis Plan, and additional support strategies developed during the respite guest's stay. The NC START QP, psychologist and/or psychiatrist provide support to staff and guests at respite as needed, and review clinical outcomes on an ongoing basis.

The menu of assessments provided while at respite are listed in the admission and discharge summary form **(see attachment)**. The NC-START clinical team, home LME, caregivers and guests work in close collaboration to define the goals of each admission, objectives to meet those goals and follow-up support provided by the NC-START clinical team to ensure a successful outcome.

Planned Clinical Respite Stays

NC- START programs also offer six planned respite beds, statewide. The programs provide planned respite to help prevent the need for emergency services whenever possible. Planned respite stays are on average a maximum of three days per visit, but can be as long as one week per visit. Planned respite beds at NC-START are intended to serve individuals who have not been able to use respite in more traditional settings due to their on-going mental health and/or behavioral issues. Our focus is on families for this service, but others may be eligible with the team's approval. Planned respite can also be utilized as a tool for crisis prevention, particularly for individuals who have a higher likelihood for experiencing crises. Families participating in the program must be approved as eligible for these services, but once approved, they schedule visits as needed (when available).

For all guests, clinical services provided while at START respite include: diagnosis and treatment formulation, symptom monitoring, emergency support/ one to one staffing, hospital diversion, community transition from hospital, family support and education.

Transitional/ Planned Visits to Respite

Transitional/Planned respite visits are provided to any START service recipient who needs assistance in transitioning to planned respite or who needs monitoring but does not require an overnight stay. An individual can visit respite for dinner, a recreational activity, or to just "check in" for a few hours.

Systems Linkages

Formal affiliations are a key process to the NC START program. These agreements link the NC-START program with the State Psychiatric Hospitals, State Developmental Centers, Local Management Entities (LMEs) and community hospitals with inpatient psychiatric units see
Table 1.

Affiliates are partners with signed linkage agreements whom NC -START maintains frequent and ongoing collaboration as part of the infrastructure. This includes an affiliation with the National Center for START Services at the UNH Institute on Disability through our work with Dr. Beasley, which allows us access to trainings offered to other START teams nationally, the national database now in development, and the ability to work on federal grants with other START teams.

Further, NC-START has numerous partners in providing services in the community; partners are defined as those agencies with whom NC-START does not have a formal affiliation agreement, but with whom they work in collaboration.

See Table below that outlines our linkages developed in the first year of operation. This is expected to expand over time.

NC START Affiliates and Partners

Affiliates	Community Partners
North Carolina Division of MH/DD/SAS	Mobile Crisis Management Providers
LME's	CAP MR/DD Providers
State Developmental Centers	ICF/MR Providers

State Psychiatric Hospitals	Community Physicians
NC START East, West and Central	Community Behavioral Health Providers
Center for START Services UNH/IOD	Residential Providers
	Hospital Emergency Departments
	Pharmacies
	Urgent Care
	Schools
	Community Hospitals with Inpatient Psych

Data Collection

One way in which NC -START is accountable to stake-holders for services provided is through the maintenance of a database. Analysis of service outcomes provides the information needed to ensure NC - START is effective in meeting its mission. Analysis includes measures of appropriateness and accessibility. NC-START tracks services provided to include clinical and programmatic information. We can also learn who is using our services and evaluate service effectiveness over time. The information provided by NC - START could also be instrumental when considering the development of new and/or specialized services. In our first year of operation, NC-START has worked in close collaboration with the Division MH/DD/SAS to provide information needed for reporting. We are now in the process of developing a more detailed database with the support of the National Center for START Services that will offer opportunities for more detailed analysis in future years of operation.

Technical Support/ Consultation

Critical to the development and progress of the project is the role of Joan B. Beasley, Ph.D., a national consultant. Dr. Joan Beasley is a licensed mental health counselor and holds a Ph.D. in Public Policy from the Heller School at Brandeis University. She has worked to promote the development of effective services for people with disabilities and their families for more than 30 years. Along with the late Dr. Robert Sovner, she co-founded the START/ Sovner Center program, which she directed from 1989 until

2000. She currently serves as the Director of the Center for START Services at the University of New Hampshire's Institute on Disability. The Center is dedicated to evidenced based development and implementation of effective services and supports to individuals with developmental/intellectual disabilities and behavioral health care needs and their families.

Dr. Beasley continues to play an active role in the NC START project. She spends time monthly in formal review, supervision, and feedback with NC-START staff, and is available at all times for remote consultation. She is an integral part of the NC-START team and critical in the continued growth and success of NC-START.

Statewide Findings in the first year of operation

The current report summarizes information available in the current database.

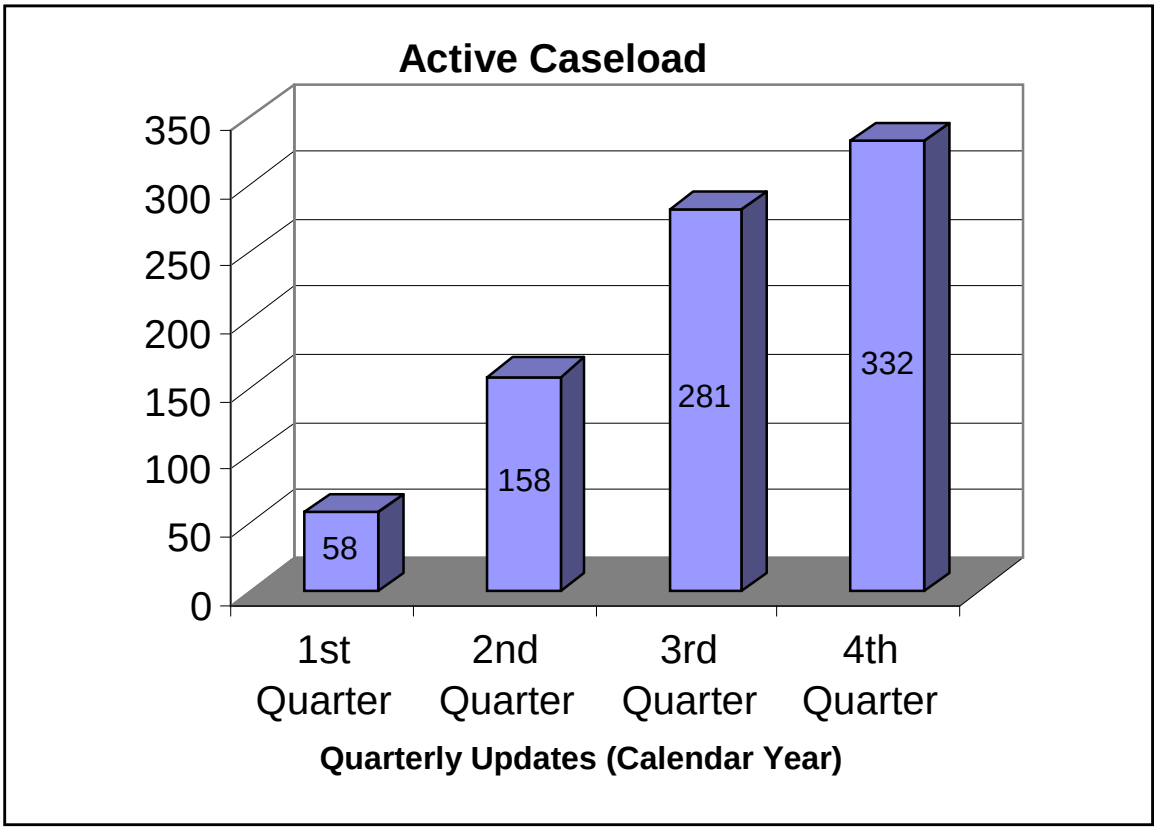
Descriptive information

The descriptive information for the first year of operation includes: number of individuals served, gender, age distribution, diagnoses at time of referral, residential setting, funding sources, level of ID, psychiatric diagnosis, medical diagnoses, prior psychiatric hospitalizations, reason for referral/ chief complaint.

Number of clients served

As shown in Table 1, the cumulative caseload statewide in fiscal year 2009 was 332. On average the increase in numbers served was 28% per quarter. The current average caseload is 25. Based on these findings it is projected in the next fiscal year we will have an active caseload of 512 individuals. With 13 current NC START QP's, this would result with an average caseload of 39 individuals per clinician. This is a concern due to the size of each region and the recommended caseload of 30 for each clinician.

Table 1

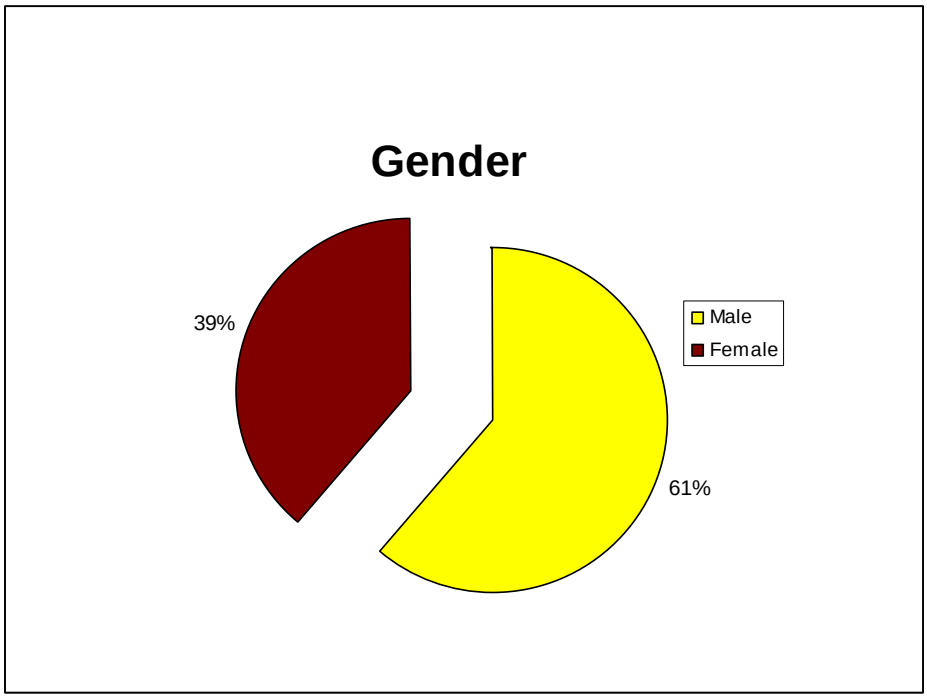


Gender

As indicated in Table 2, 61% of those supported by NC START are male. This finding is consistent with other program findings. However, the degree to which males are dominant is greater than usual.

Table 2

Gender of NC START referrals year one of operation

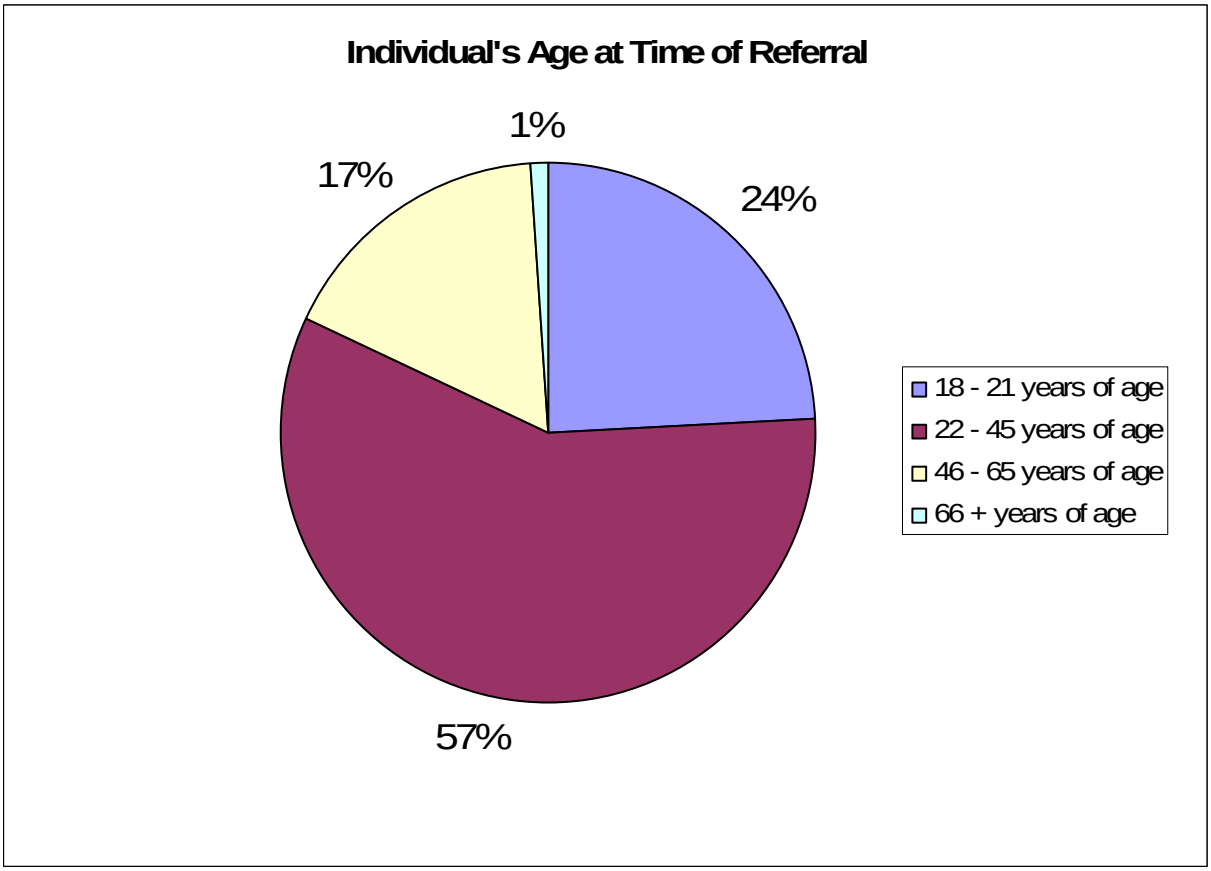


Age distribution

As indicated in the table that follows, while the majority of referrals fall into the category of adult (57%), a significant number of individuals referred to NC-START in the first full year of operation would fit into the category of "transitional youth" (24%). This is followed by adults age 46-65 (17%) and seniors (1%).

Table 3

Age Distribution

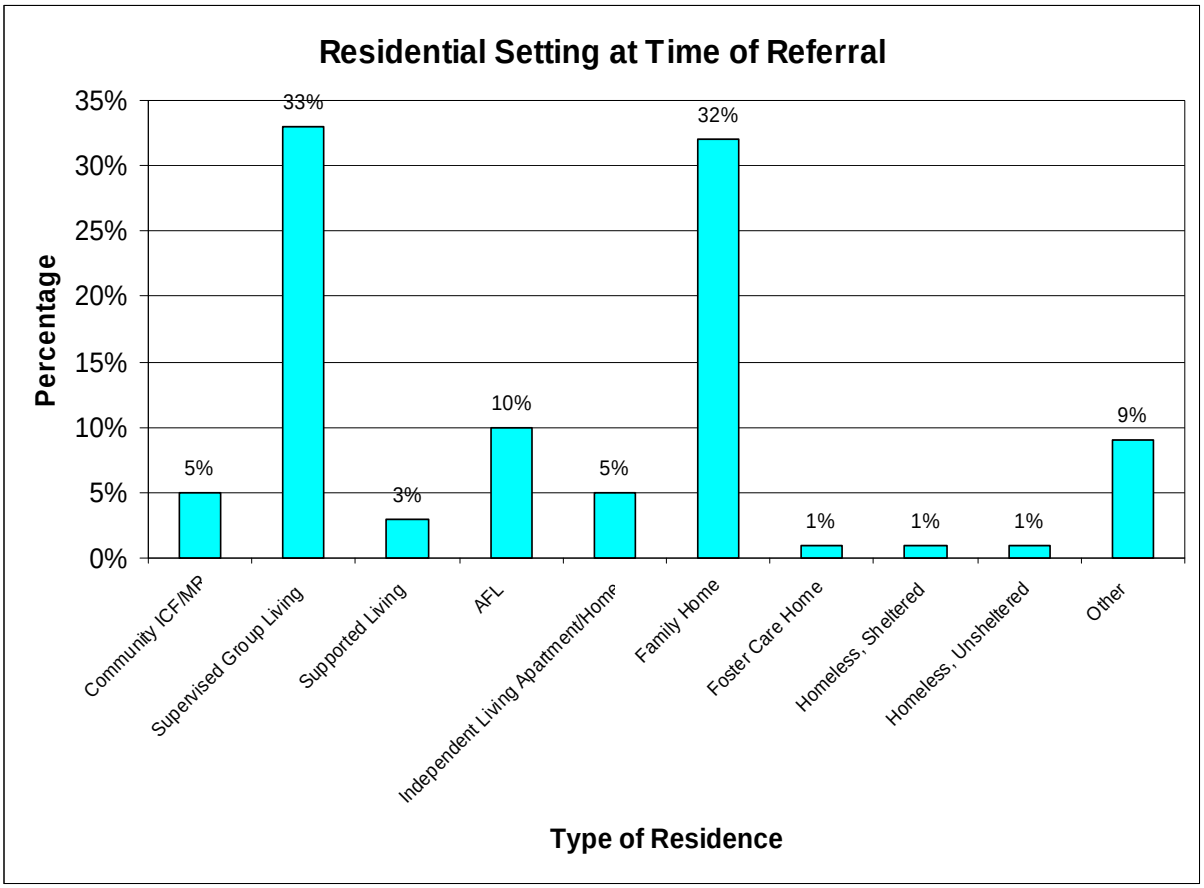


Residential Settings at time of referral

The data primarily denotes a bimodal distribution of residential settings with the highest frequencies in Supervised Group Living (33%) and Family Homes (32%) (see Table 3). This is important, as often NC - START is a primary resource available to help families stay together when difficult times arise. It is noteworthy that 32% of the people we serve live with their families. As has been found in other applications of the model, we expect up to 50% of the people served over time will live with natural supports (families).

In addition, 10% of the individuals resided in AFLs, while 9% were identified as "other residential setting" at time of referral, 5% live independently, 5 % live in community ICF/MR homes, 3% lived in supported living homes, and another 2% of the individuals lived in shelters or were categorized as homeless. In addition, 1% lived in foster care homes.

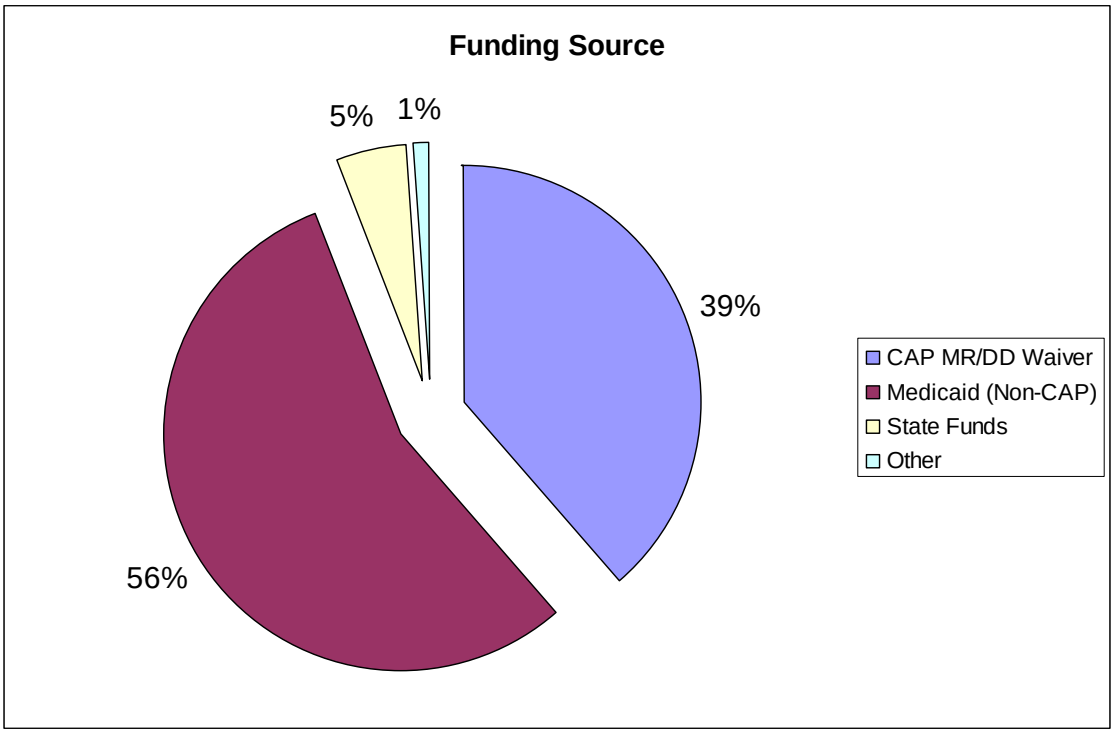
Residential Settings at Time of Referral



Funding Source

Fifty-Six (56%) of individuals supported by NC- START in calendar year 2009 had Medicaid funded health care services; 39% percent had the CAP MR/DD Waiver funding source; 5% only had state funded services (i.e. IPRS and no other funding source); 1% had “other” funding sources (e.g. Medicare, NC Health Choice). This analysis is limited to the primary funding source at this time. Next year’s data base will capture multiple funding sources.

Funding Source



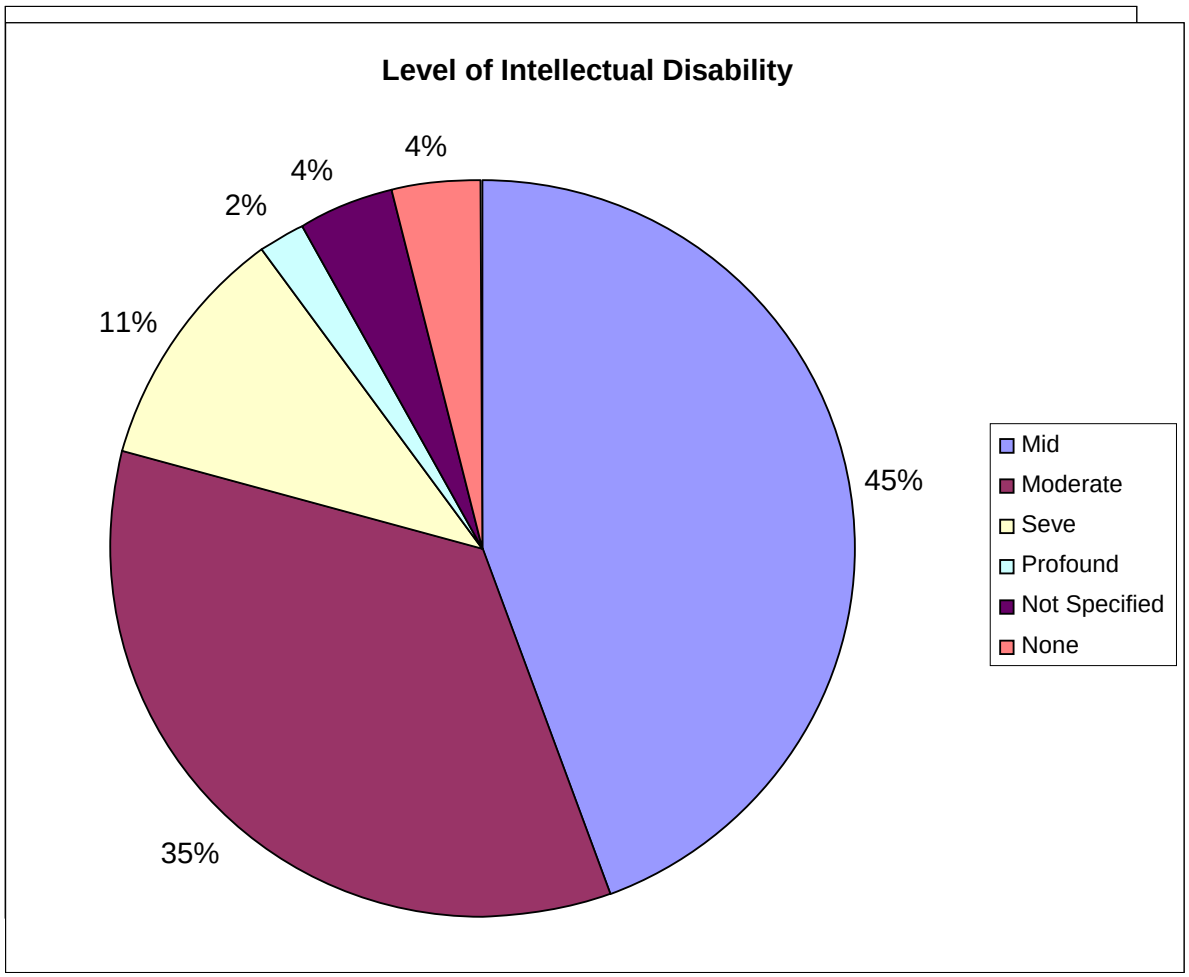
Reported Level of Intellectual Disability

Following is a table to denote level of intellectual disability reported at the time of referral. Forty-Five Percent (45%) are in the mild range of mental retardation (IQ between 50-55 and 70); 35% are moderate (IQ between 35-40 and 50-55); 11% are severe (IQ between 20-25 and 35-40); 2% are profound (IQ below 20-25); 4% are not-specified (generally related to individuals with Autistic Disorder); and 4% had

no Intellectual Disability. The level of intellectual functioning for another 11% is unknown; see Graph that follows.

In the general population of persons with mental retardation, 85% are in the mild category, 10% moderate, and 3% severe/profound. Overall, this indicates that individuals referred to NCSTART have greater impairment than the general population of individuals diagnosed with ID. The finding is consistent with other START program findings, and may indicate that people with greater impairment are more vulnerable to suffering from co-occurring disorders, people with greater degrees of impairment are more complex to treat in the mental health system, or both.

Percent of Clients in Each Category of Intellectual Disability (At Time of Referral)

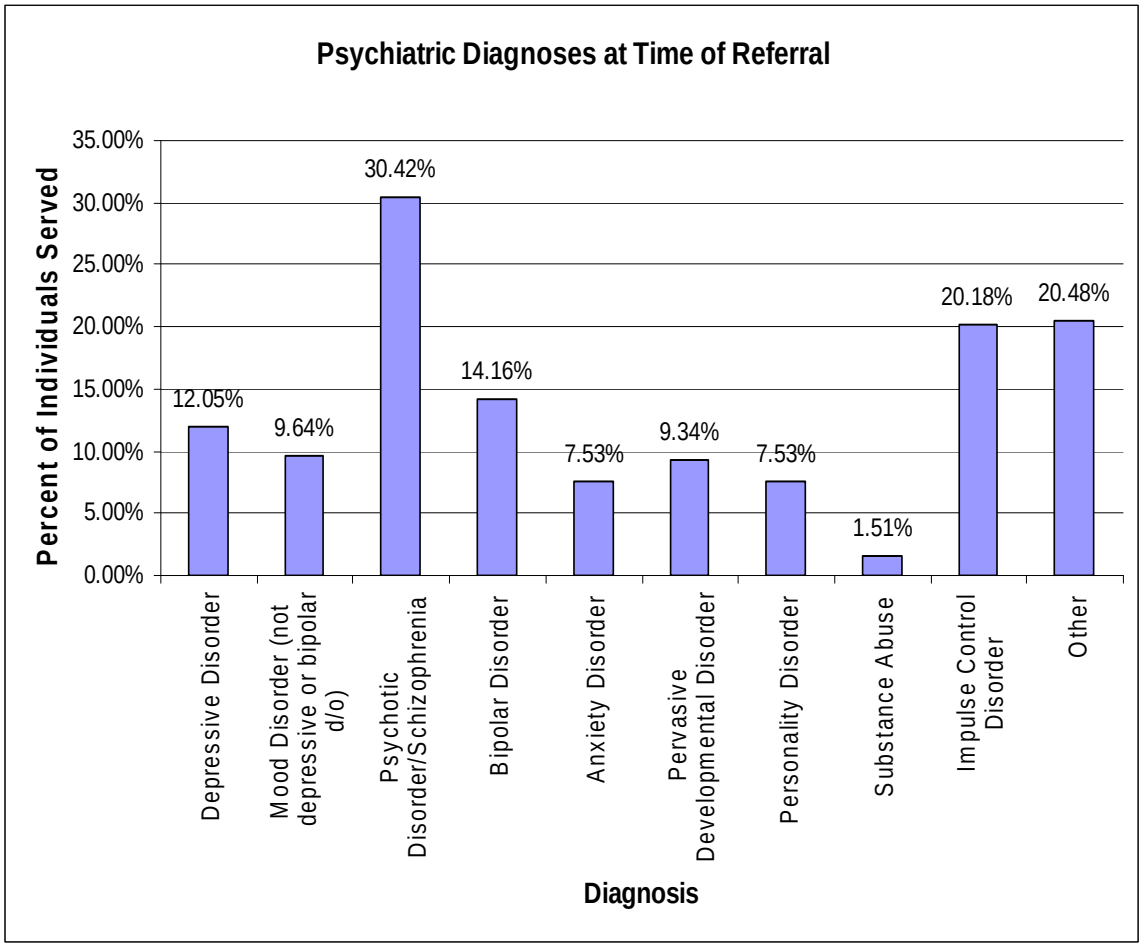


Reported Psychiatric Diagnoses at the Time of Referral

The mental health diagnoses reported at the time of referral are portrayed in the following table. The most common diagnoses include: Psychotic Disorder/Schizophrenia (30%); Impulse Control Disorder (20%); Bipolar Disorder (14%); Depressive Disorder (12%); Pervasive Developmental Disorder (9%) and Other (e.g., Oppositional Defiant Disorder, Attention Deficit-Hyperactivity Disorder, Disruptive Behavior Disorder; 7%). Only 8% of NC -START referrals had a diagnosed anxiety disorder at time of referral. This is of interest because it does not represent what is currently known about the population, where anxiety disorders are more prevalent. This is also the case for the diagnosis of Depression.

The diagnosis of psychotic disorders is far more prevalent than expected and may indicate that some of these individuals require additional diagnostic assessments. A number of individuals had two or more mental health diagnoses,

Psychiatric Diagnoses at Time of Referral



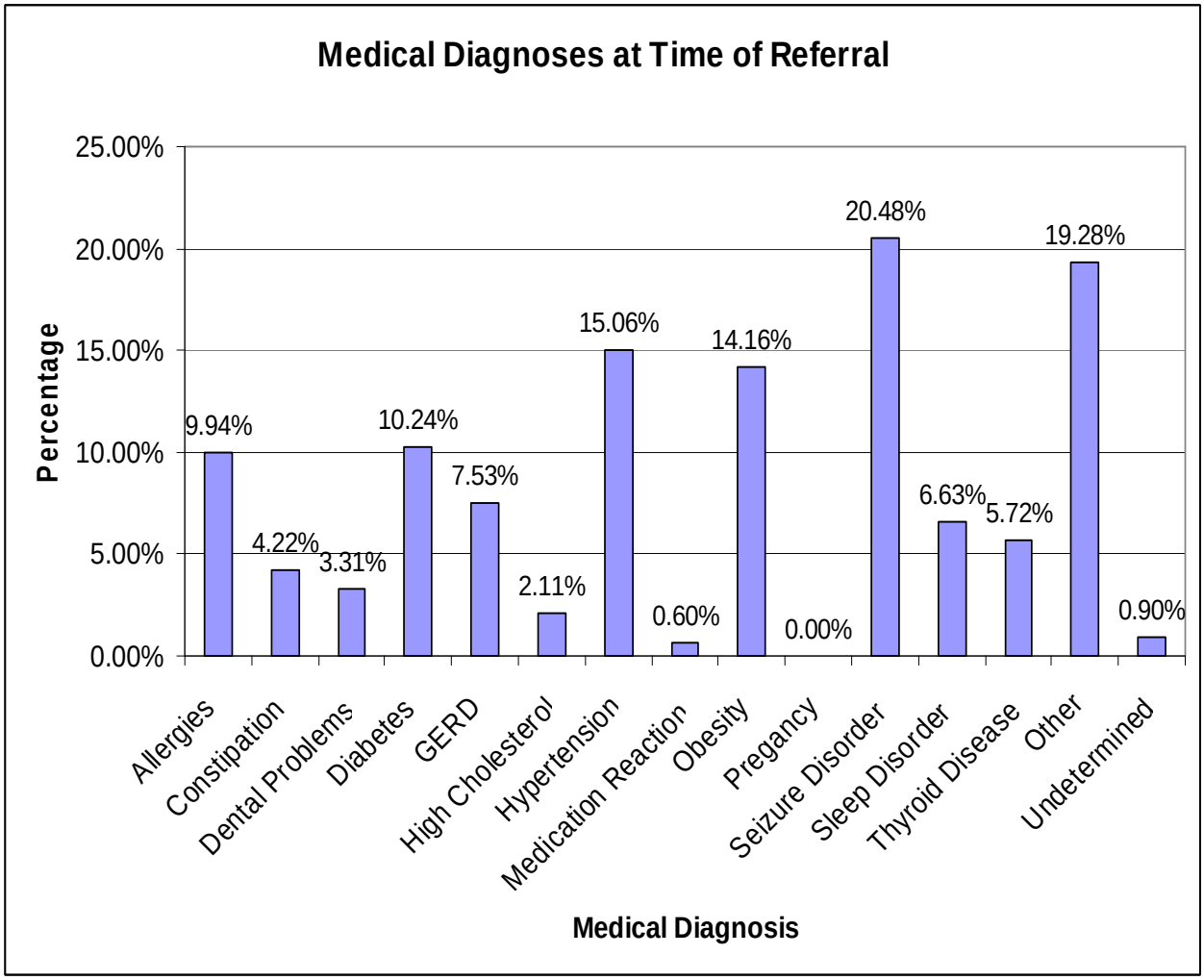
Reported Medical Diagnoses at time of referral

Medical diagnoses of clients at the time of referral are displayed in the table below. It is not surprising that a large number of referred individuals had seizure disorders, hypertension, obesity, diabetes and allergies. This finding is consistent with the finding that people referred to NC START overall are more fragile than the general population of ID service users. We know that the severe and profound populations are far more likely to have seizure disorders than their counterparts, for example.

The most common medical diagnosis was seizure disorder (20%). The "Other" medical disorders category included osteoporosis, genetic disorders, kidney disease, and acne as well as other less frequently occurring ailments, was the second most-common(19%) . Hypertension was found in 15% of the cases referred. Obesity was 14%, this is lower than the state average of 24%. However, 10% of the population has diabetes, 10% has allergies, 8% of the group was reported to have GERD, and 7% of the group had a diagnosed sleep disorder at the time of referral. In addition, 6% of the group was reported to

suffer from thyroid disease. Only 4% of the population was reported to have constipation and 3% had dental problems, these are lower than expected when compared to other like populations. An additional 2% of the population was diagnosed with high cholesterol. Medication effects are far lower than expected (less than 1%) given the prevalence of other medical conditions often associated with medication effects, and the age of the group. This calls into question whether medication effects need further consideration.

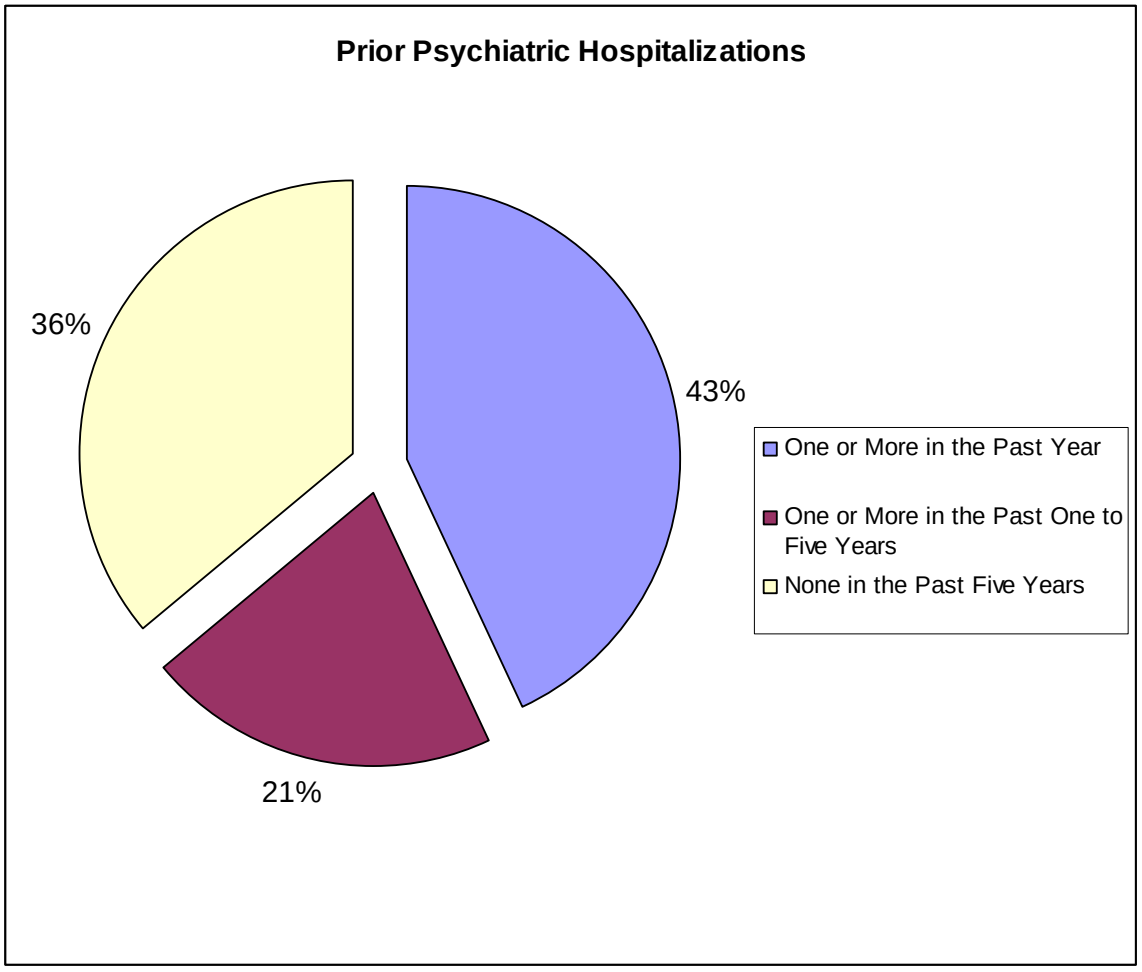
Medical Diagnoses at Time of Referral



Reported Prior Psychiatric Hospitalizations at Time of Referral

It is noteworthy that 64% of referrals had prior psychiatric hospitalizations, with a significant percentage (43%) of individuals hospitalized within the past year. The majority of clients had admissions and may indicate that some individuals who may not have required hospitalization were hospitalized in the past due to a lack of alternatives. It is our goal to monitor outcomes in hopes of reducing the need for inpatient care.

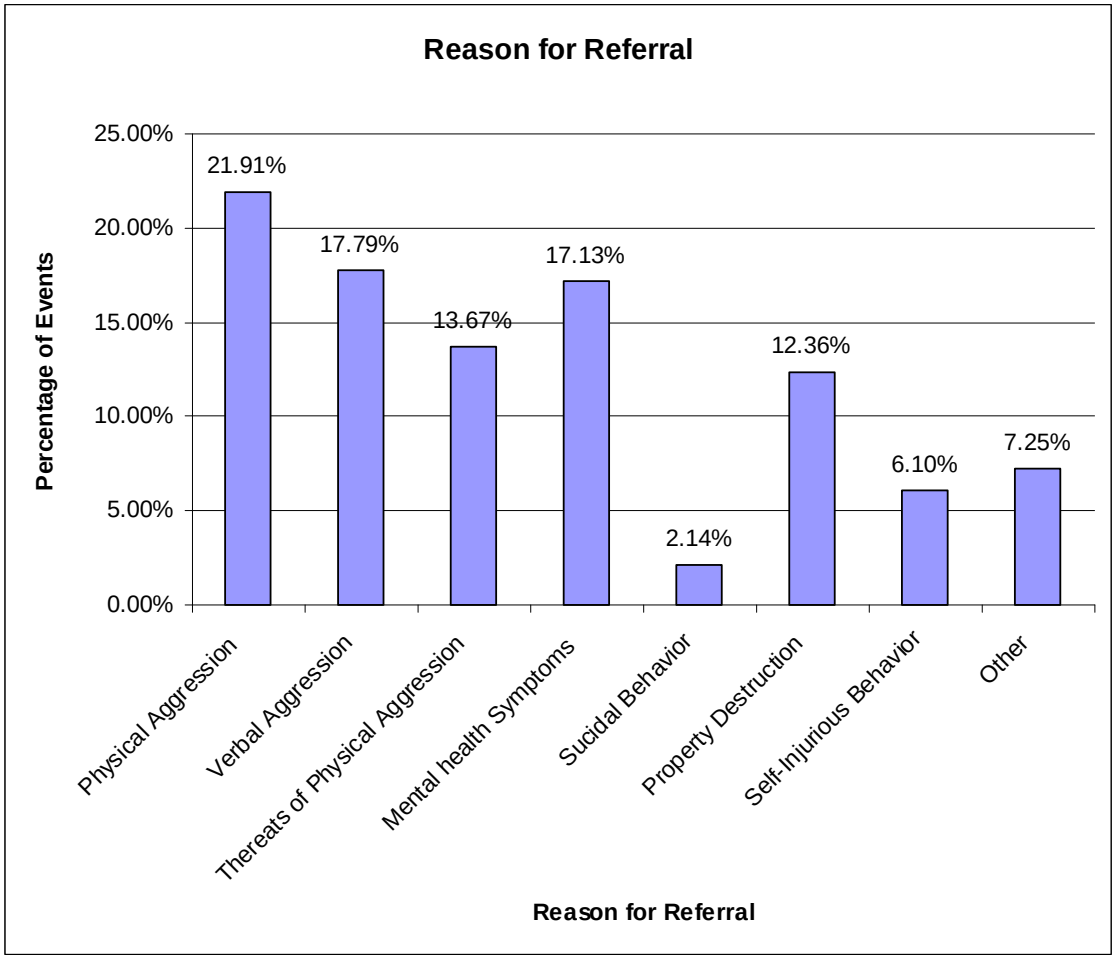
Number of Prior Hospitalizations (At Time of Referral)



Chief Complaints/Reasons for Referral at time of referral

The chief complaints or reasons for referral to NC -START are shown below in the graph that follows. Physical aggression (22%) is the most frequent reason for referral. Mental Health Symptoms (19%) depression, anxiety and hallucinations are the prevalent tissues reported here, verbal aggression (17%), property destruction (15%) and threats of physical aggression (14%) were also common reasons for referral. It is interesting that these most frequent reasons for referral are externalizing behaviors (approximately 75% of reasons reported). It may indicate that an individual had difficulties that were undetected prior to extreme disruptions to others as found in aggression. It demonstrates the need for appropriate psychiatric and mental health services for this population, including a better understanding of how to diagnose individuals with ID, learn about communication styles, and help to prevent crises. In addition, they are more likely to use emergency and restrictive services if these concerns remain unresolved.

Chief Complaints/Reasons for Referral



NC -START Service Outcomes in first year of operation

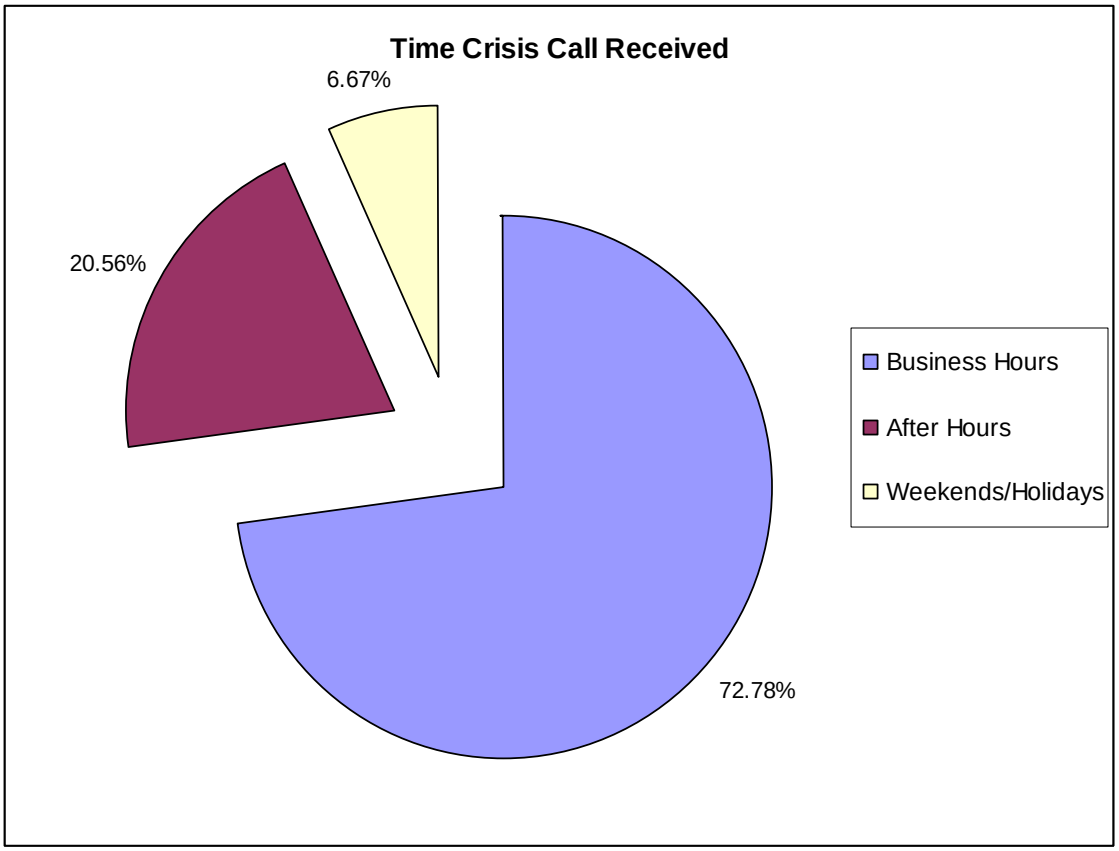
Crisis services

Crisis services include the following: phone consultation, onsite consultation, prescreening for crisis respite, emergency intake meetings, emergency team meetings, crisis respite admissions, and admissions meetings at crisis respite and psychiatric inpatient facilities.

Crisis Calls

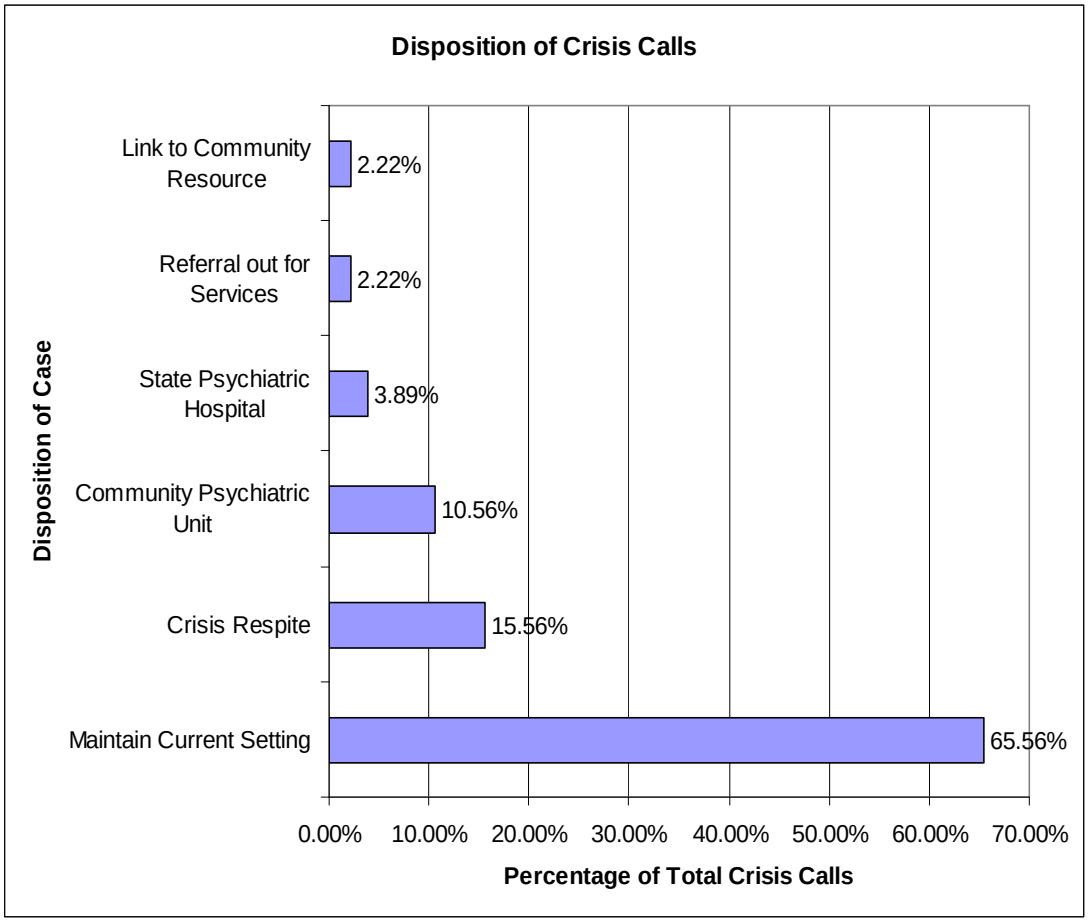
The following chart indicates the time of crisis contacts. Seventy-three percent (73%) of crisis contacts occurred during business hours, It is important to note that 27% of services were provided after hours and on the weekend.

Time of Crisis Calls



Dispositions associated with Crisis Calls

The vast majority (66%) of all crisis calls resulted in the person's ability to remain in their current setting. An additional 16% were admitted to NC-START emergency respite beds for a total of 82% requiring no additional emergency support other than NC-START. An additional 11% went to community based inpatient mental health facilities and were followed by the NC START team, and an additional 4% were hospitalized in State Mental Health facilities also followed. During the time of crisis contact, NC START assisted 4% of individuals with referrals to other services or linked to community resources when they did not meet the criteria for NC-START.



Planned services and supports with regard to individual service users

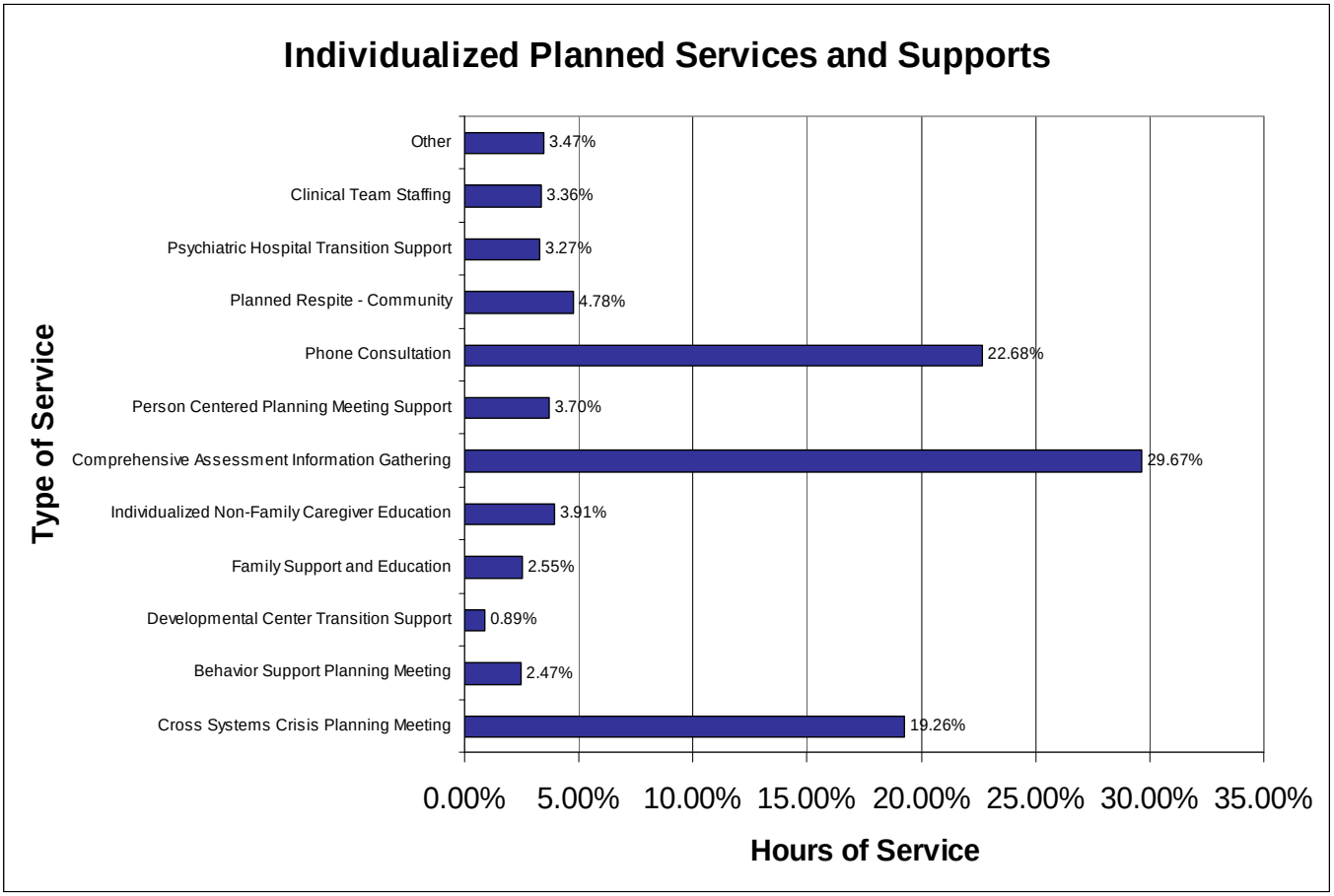
In addition to crisis contacts, many of the services provided are scheduled to assist individuals and their support teams. NC START staff members are asked to document all hours spent providing services. The Table below portrays the percentage of time spent providing planned services to individuals followed by NC- START.

The majority of time was spent on record review, interviews with caregivers and providers and other forms of information gathering to gain a better picture of the individual referred (30%), This was followed by planned meetings/phone consultations conducted over the phone (23%), and cross systems crisis planning meetings (19%). Planned respite was provided in the person's home (5%) of the time, while caregiver education to paid support was provided 4% of the time. NC-START staff participated in person- centered planning meetings 4% of the time. "Other" category of services includes observations of individual while at Respite and occurred 3% of the time. Clinical team case (staffing) reviews occurred 3% of the time, while psychiatric transition support meetings and contact occurred 3% of the time. Family support and education occurred 3% of the time in our first year of operation, while NC START participated in behavior support planning meetings 2% of the time. We also had the opportunity to work with developmental centers for transition meetings 1% of the time.

Planned and Outreach Services to individuals referred to NC START in the first year of operations

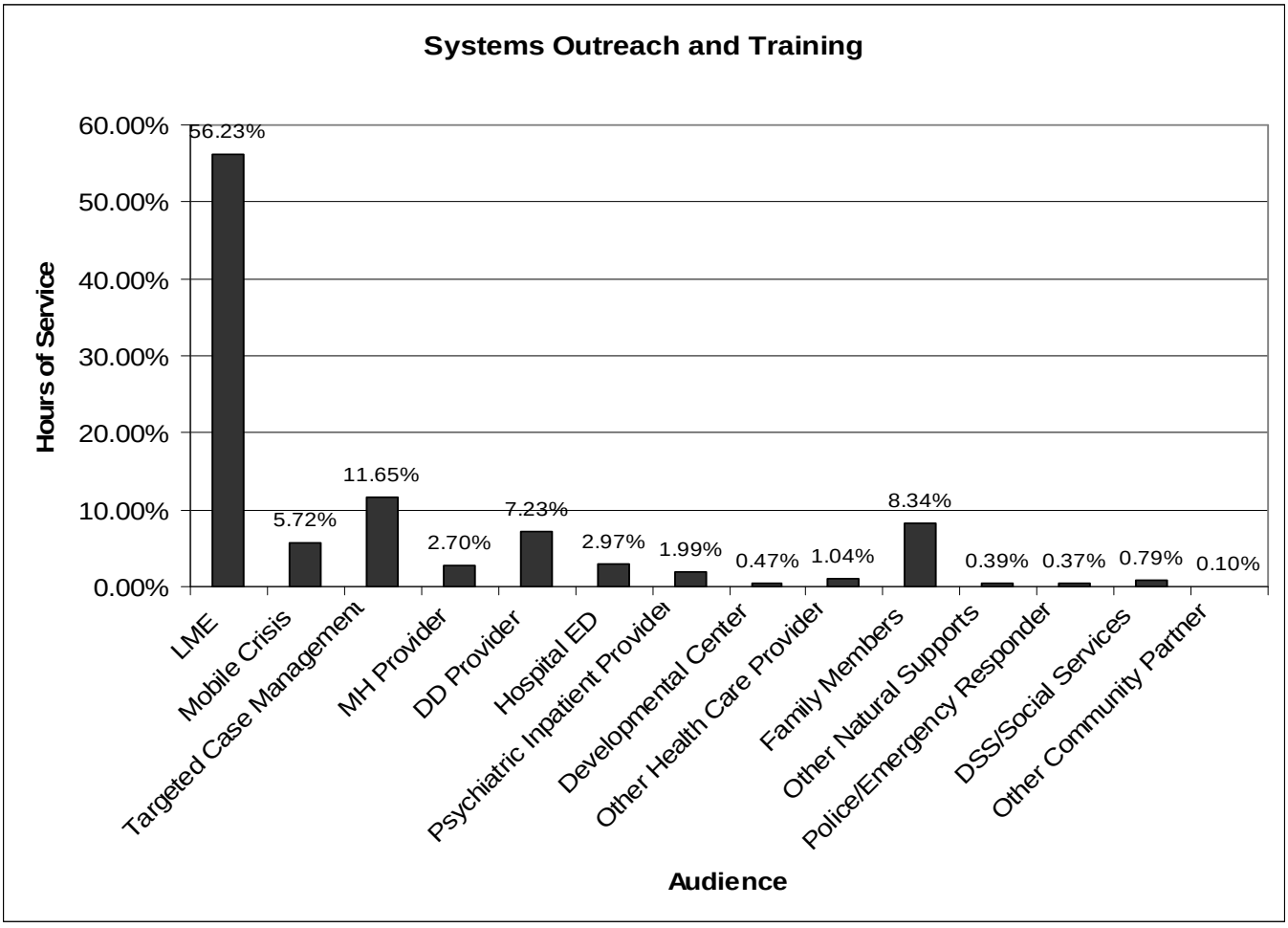
Planned Systems outreach and training

Systems outreach and training defines services provided that are systems focused rather than individual service user focused. Our most active partners were the LMEs followed by targeted case managers. NC-START spent 56% of time providing outreach to LMEs, while 12% of the time was devoted to outreach with targeted case managers. Family members received non-client specific services to families 8% of the time, this included meeting with a number of family groups and support groups to inform families about NC START. In addition, outreach to formal meetings with DD providers occurred 7% of the time spent providing outreach to systems. Furthermore, 6% of services were provided to mobile crisis teams, while we met with hospital emergency department, and mental health s 3% of the time each. We had outreach contact with psychiatric inpatient providers 2% of the time and other health care providers 1% of the time. We had contact with DSS/Social Services 1% of the time.



Systems outreach and training

Systems outreach and training includes trainings to potential partners, affiliates and other systems in addition to presentations to inform providers about the services offered at NC-START. Not surprisingly, the greatest amount of outreach occurred with LMEs at 56%, followed by targeted case managers at 12%. This was followed by outreach to family organizations and forums at 8%, DD providers council at 7%, mobile crisis teams (6%), hospital ED at 3%, mental health service providers (3%), psychiatric inpatient provider at 2%. We also reached out to other health care providers and DSS for a total of 2% of the time spent this year with outreach.

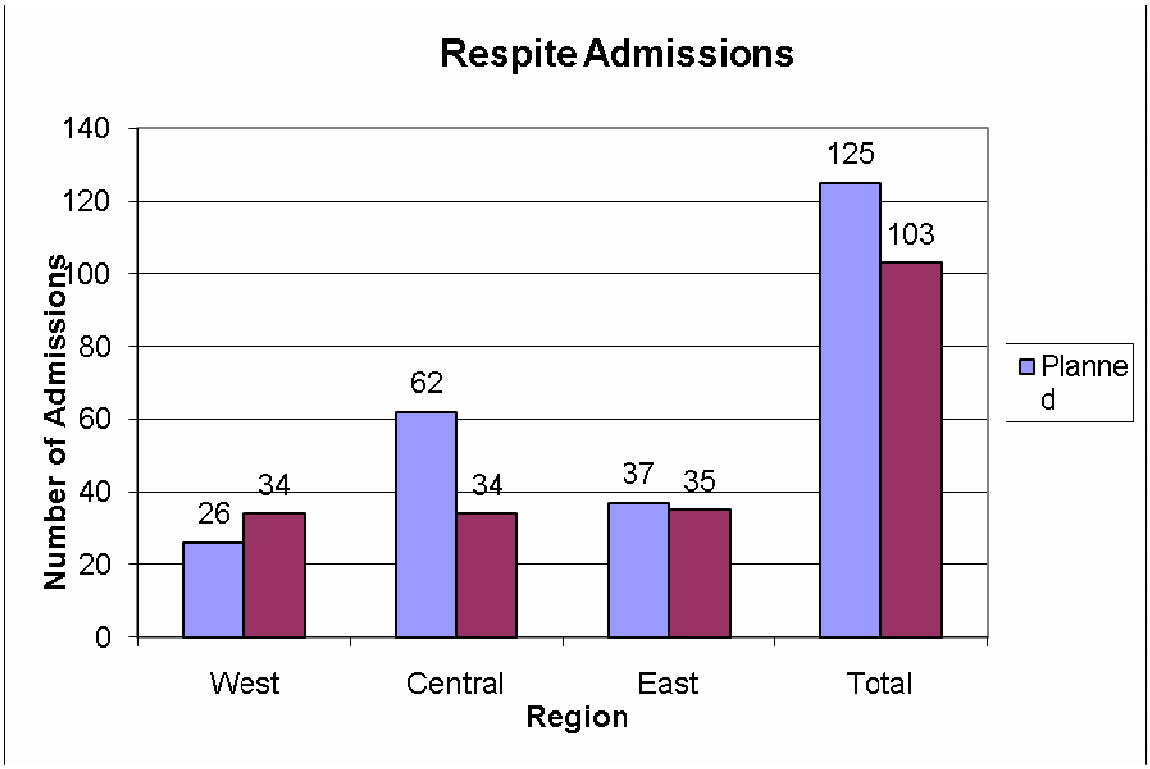


NC-START Respite

The total number of admissions to respite for the state in the first year of operation was 228.

The vast majority of admissions for planned respite occurred in the Central region. This may be explained in part by the composition of the region. The central region is not as vast as the other two and the respite facility may be more accessible as a result. In the West region, Western Highlands is collaborating with the other LMEs to provide funds for transportation to families in need, in hope of improving access to respite.

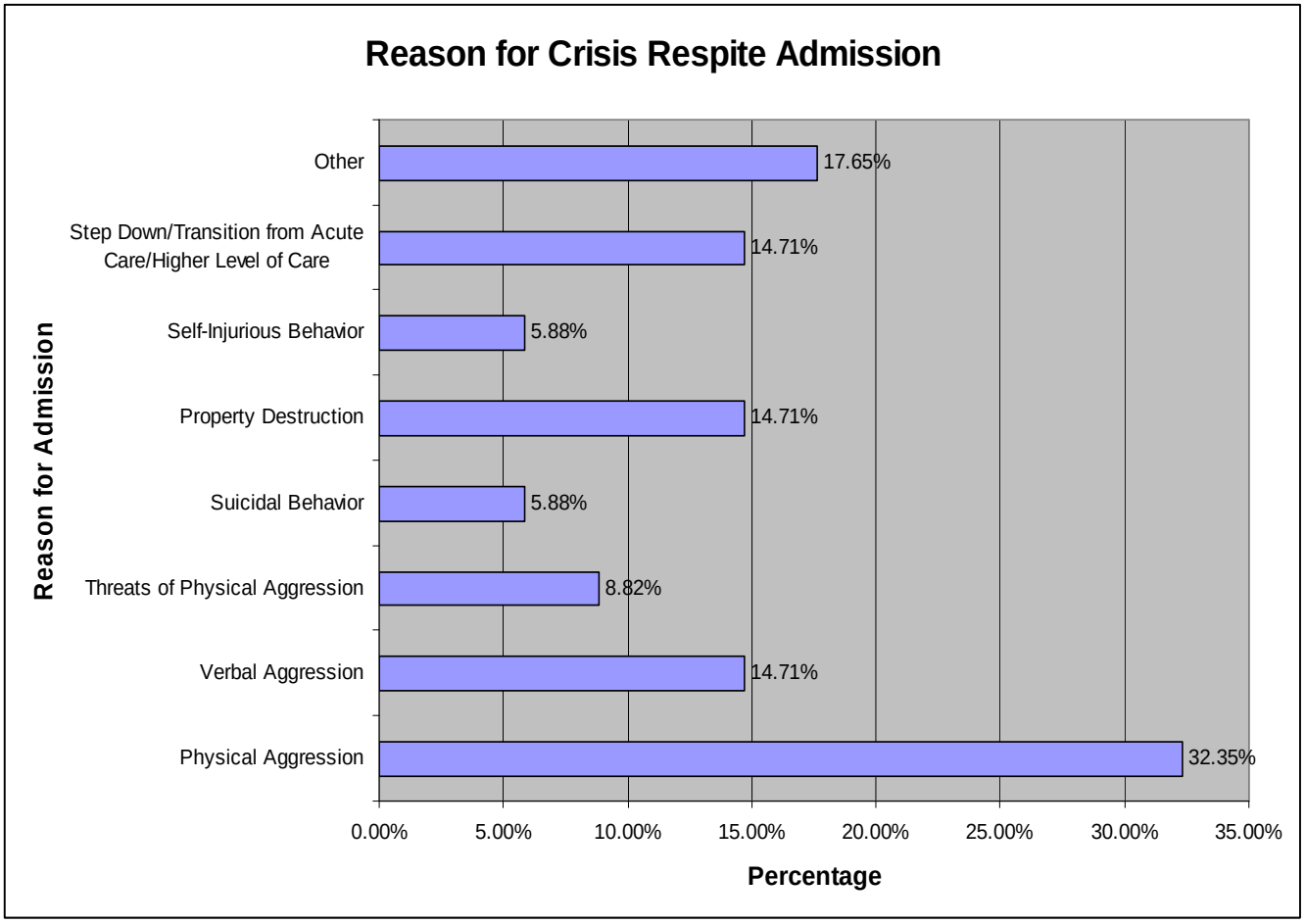
The rate of emergency respite admissions to all of the respite programs was the same across the state.



Reasons for respite admissions:

The reasons for respite admissions as described by referral sources are outlines in the table below. Not surprisingly, the primary reason for emergency respite is physical aggression (41%) this finding is consistent with those found in other START respite programs. This was followed by threats of physical aggression (17%). The other category (12%)consists of what we called “planned emergencies”, or those events that you anticipate would worsen if not for an emergency respite admission. Transition from acute care was 11%. Self injurious behavior was the reason for admission reported 10% of the time, while property destruction and suicidal behavior were the cause of requests 5% of the time each. Of note is the

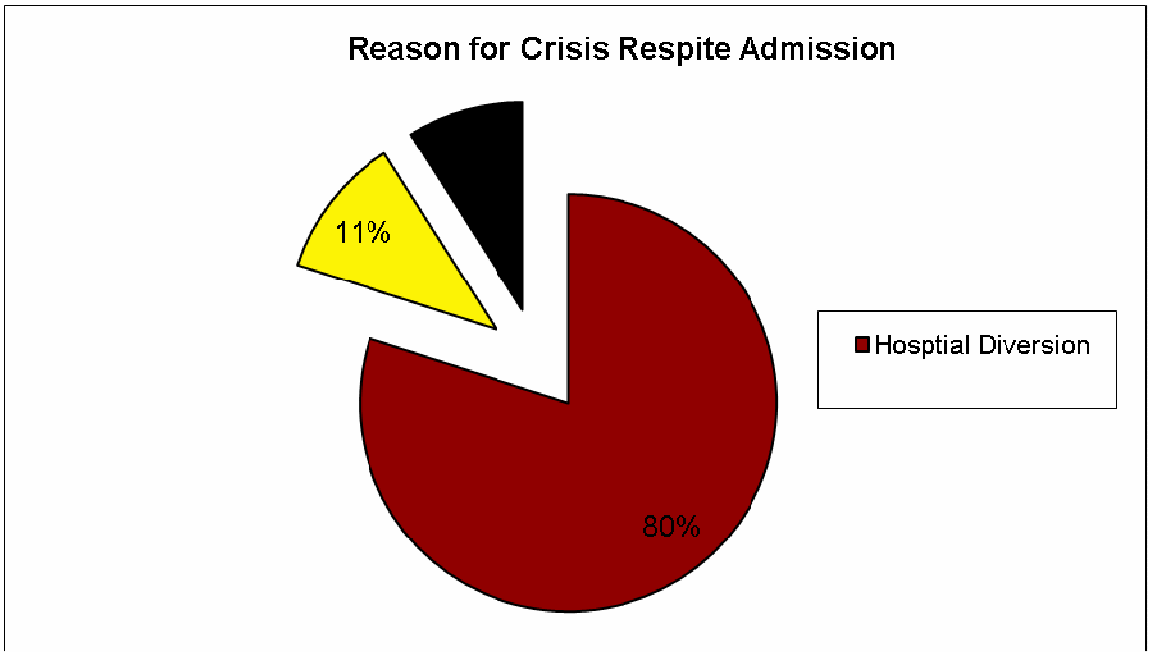
prevalence of reasons for referrals that coincide with disturbance to others in the person's current setting.



Purpose of admissions

The Purpose of crisis respite admissions is outlined in the tables that follows. Of great interest, 80% of the time, crisis respite served to provide hospital diversion, and important finding. This was followed by transition back home form hospital, and this served to abbreviate stays (in yellow) followed by other 9% which includes family emergencies, systems issues and admissions associated with crisis plans.

Purpose of Crisis Respite Admission



Cross-Systems Collaboration, Training and Education Services

NC -START services also include Cross-Systems Collaboration, Training and Education. NC -START has worked cooperatively with outpatient mental health centers, inpatient mental health facilities and hospitals, and is building working relationships with the local medical community. Collaborative meetings between NC -START and the following entities occur on a regular basis: State Psychiatric Hospitals, Developmental Centers and Local Management Entities (LMEs).

NC -START has also provided presentations of the program to the following: LMEs, Mobile Crisis Teams, Targeted Case Management providers, DD Service Providers, MH Service Providers, Hospitals, Emergency Departments, Psychiatric Facilities, Developmental Centers, Families, Social Service Agencies, and Police/Emergency Response. This has lead to formal affiliations in some cases (as discussed above), and has provided the opportunity to more formally determine how we collaborate.

NC -START hosts Clinical Team Meetings to which professionals working across systems are invited, where cases are reviewed. In this forum, we learn from one another
across disciplines and systems, and to work collaboratively.

NC START has presented at the NC Council for Community Programs Conference and Eastern AHEC Developmental Disabilities Conference. NC START has provided Introduction to Dual Diagnosis to

Dorothea Dix Hospital Social Workers and Crisis Planning for Individuals with Developmental Disabilities to Wake County Developmental Disabilities Collaborative.

The NC -START staff also receive ongoing training through attending state and national conferences, as well as receiving regular training and supervision (see Table for training staff have received). Dr. Beasley provides in-service trainings, and conducts monthly reviews of Crisis Plan development. The QP Clinicians receive weekly group supervision as well as individual supervision with the senior clinicians (Director, Clinical Director, and Medical Director.

Training/Consultation Attended by NC -START Staff

Training Topic	Presenter
NADD Conference/Several topics on persons with dual diagnoses	Various
NC START Model	Joan Beasley, Ph.D.
Conducting Emergency Mental Health Evaluations of Individuals with Intellectual Disabilities	Joan Beasley, Ph.D.
Psychopharmacology and Medication Management for Mental Health Disorders	NC START Medical Directors
Autism	Jill Hinton, Ph.D.
Genetic Disorders in DD	Jill Hinton, Ph.D.
Positive Behavior Supports	Jill Hinton, Ph.D.
Mental Health Aspects of Autism	Jill Hinton, Ph.D.
4 part training for physicians and prescribers	Jarrett Barnhill, M.D.
START Respite Services for Individuals with DD and their Families	Joan Beasley, Ph.D.
Introduction to Psychotropic Medications	NC START Medical Directors
Psychiatric Diagnoses and Symptoms	NC START Medical Directors
Mental Health Aspects of Intellectual Disabilities	Joan Beasley, Ph.D.
A Comprehensive, Integrated Clinical and Systems Approach to Effective Long-Term Clinical, Direct Support, and Crisis Planning	Joan Beasley, Ph.D.
Family-Professional Collaboration	Joan Beasley, Ph.D.
A Structural/Strategic Approach to Consultation	Joan Beasley, Ph.D.
Systemic Consultation with Live Supervision	Joan Beasley, Ph.D.
Cross-Systems Individual Crisis Prevention and	Joan Beasley, Ph.D.

Intervention Support Planning	
Specific Clinical Skills (e.g., Supports Intensity Scale, Assessment and Treatment Planning, Team Building, Documentation)	NC START Clinical Directors NC START Directors

Goals for Fiscal Year 2011

There are several areas of development that will be addressed in the coming year. NC -START will:

1) Finalize a comprehensive data base for NC START.
2) Develop affiliations with community hospitals. The primary goal is to improve access to local hospitals' inpatient psychiatric services.
3) Expand relationships with local community partners (i.e. behavioral health provider agencies, mobile crisis management teams, hospital emergency departments, private physicians, residential providers, law enforcement, etc.). NC -START will continue to expand these networks within our current service area, and strive to identify and overcome obstacles to needed services.
4) Survey families and individuals regarding service experiences. Surveys will be part of the intake process and will be repeated annually to assess improvements in service experiences from the perspective of those who utilize them.
5) Improve access to planned services. We will explore obstacles to planned respite and develop ways to overcome them, including access to transportation.
6) Continue to develop expertise, access training opportunities whenever possible and review current literature.
7) Continue to strive for excellence in services we offer. Ongoing consultation and training, dialogue with affiliates and partners, feedback from stakeholders, and the use of an interdisciplinary approach with continued attention to service outcomes will assist us as we move forward to provide the most effective services possible.

Attachment 1 - NC -START Advisory Council

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Attachment 2

Cross-Systems Crisis Prevention and Intervention Plan

PART I - FACE SHEET

Demographics	
Name:	LME Region:
Date:	Medical Record:
D.O.B.:	Telephone #:
Address:	Medicaid #
	Medicare #:
	Private Ins

Living Situation (check appropriate box):	
☐ lives with family	☐ lives alone
☐ lives alone with supports	☐ lives in residential program
Describe:	

	Diagnosis	Dates Diagnosis Given and who gave it (may also include questions for follow up)
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V		

Current Medication
As of : ____/____ /____

Medication	Dose	Frequency	Prescribing Doctor	Condition for which it's prescribed	Date started

Medical/Dental Conditions

Communication Style - Primary Language

Strengths/Skills/Interests

System of care/PROVIDERS

Type	agency	Name	Address	phone #
Individual				
Guardian				
family contact				
Targeted Case Psychologist				
Therapist				
Psychiatrist				
Primary Physician				
Day Program				
Work Program				
Residential Program				
Neurologist				
Community Respite Program (if able)				
LME Representative				
MCM Rep.				
NC START QP				

PART II - GENERAL GUIDELINES

Describe general patterns of behavior, personality traits, etc. that are part of who the individual is: (i.e. has a good sense of humor; skills, interests, does best when given "space", ways to develop rapport, etc.):

Describe the individual's home living situation and environment:

Describe factors that create increased stress for the individual (i.e., anniversaries, holidays, noise, change in routine, anticipation of a planned event, fatigue, inability to express medical problems or to get needs met, etc.):

Describe the nature of any legal involvement the individual has had. Is there or has there been any court involvement? Describe how (or if) this affects his/her supervision needs. Are there situations that care providers should be aware of in order to maintain safety for the individual and others?

Describe situations and/or behaviors that have historically led to crisis service use and/or hospitalization for this individual:

Describe person's preferred de-escalating activities preferred and other alternatives that have been effective in keeping the individual out of crisis. Have alternative services i.e. respite and diversion to hospitalization been used effectively?

A. Primary problem/ chief complaint:

B. Medical condition to be addressed (if any):

Part III

Hierarchy of Behaviors

	Stage I	Baseline needs for	least restrictive	
Behaviors/Signs/Symptoms	Setting events	Triggers	Interventions	Persons Involved/Phone

Stage II		Onset of difficulties	increased intervention	
Behaviors/Signs/Symptoms	Setting events	Triggers	Interventions	Persons Involved/Phone

Stage III		increased intensity		
Behaviors/Signs/Symptom	Setting events	Triggers	Interventions	Persons Involved/Phone

Stage IV	crisis			External
Behaviors/Signs/Symptoms	Setting events	Triggers	Interventions	Persons Involved/Phone

PART IV - DISPOSITION RECOMMENDATIONS

Specify what options have been most successful in the past; whether the individual has been to respite and does well there, which hospital is the hospital of choice, if necessary, etc.

PART V - BACK-UP PROTOCOL

Describe the systems emergency back-up protocols to support the individual:

Outline specific protocols under which the mental health crisis team or other emergency supports will be accessed.

PART VI - SIGNATURES/APPROVALS

NAME:

SYSTEM OF CARE SIGNATURES			
	Signature	date	Copy of Plan Provided (check)
Individual (OPTIONAL)			
Parent/guardian			
Other Family contact			
Case Manager/ QP			
Psychologist			
Therapist			
Psychiatrist			
Primary medical provider			
Day Program rep.			
Work Program rep.			
Residential program rep.			
Neurologist			
Respite program rep.			

NC START Respite Program Rep.			
LME representative			
Hospital ER			
Hospital Diversion			
Regional Psych. Hosptial			
Mobile Crisis			
NC START Team Member			

Attachment 3

NC START Intake Assessment

NC-START

Systemic, Therapeutic, Assessment, Respite, & Treatment

Intake and Assessment

For START Team Use Only:
Intake: / /
Clinician Init.:

Referral Date:	Individual's Name:
Medicaid Number: - - -	Record #:
Date of Birth: / /	Gender: ☐ Male ☐ Female

Person Completing Intake and Assessment:		Position:
Agency:		
Phone: - -	Cell/Pager: - -	Email:
Referral Source:		If other, please indicate:
Home LME:		LME START Care Coordinator:
Case Management Agency:		
Case Manager/ Position:		
Phone: - -	Cell/Pager: - -	Email:

Legal Guardian (if any):		
Relationship to Individual:	Restrictions on Authority:	
Address:		
City:	State/Zip Code:	
Phone: - -	Cell/Pager: - -	Work: - -
Email:		

Primary Service Agency:

Coordinator:		
Phone: - -	Cell/Pager: - -	Email:

Other Service Providers

Service	Provider Agency	County Service Rcvd	Contact Person	Phone

I. REFERRAL SUMMARY INFORMATION

A. Reason for Referral (Please check all that applies):

☐ Physical Aggression ☐ Threats of Physical Aggression ☐ Verbal Aggression

☐ Property Destruction ☐ Suicidal Ideation/ Threats ☐ Hallucinations or Delusions

☐ Self-Injury ☐ Change in Mood ☐ Other:

Risk Assessment Attached: ☐ Yes ☐ No

Describe the problem(s) leading to the referral:

Duration of problem(s): When did it start? How long going on?	
Target behavior(s): List and define	
Frequency and Intensity of the problem/ target behaviors	
Monitoring Methods: Rating scales, behavior tracking, etc.	
Description of possible	

precipitants: What may cause or "set off" problem(s)?		
Time of Day: When are behaviors most and least likely to happen?	Most Likely:	Least Likely:
Settings: Where are behaviors most and least likely to happen?	Most Likely:	Least Likely:
People: With whom are behaviors most and least likely to happen?	Most Likely:	Least Likely:
Activity: During what activities are behaviors most and least likely to happen?	Most Likely:	Least Likely:
Description of aggravating factors: What makes this problem worse?		
Description of alleviating factors: What makes this problem better?		
When was the last time this person was doing well?		
What were the circumstances at that time and what was s/he like?		

B. Changes in Person's Behavior in Last 6 Months: Please check one in each area.

Energy Level	☐ Increased	☐ Decreased	☐ No Change
Appetite	☐ Increased	☐ Decreased	☐ No Change
Weight	☐ Increased	☐ Decreased	☐ No Change
Sleep Amount	☐ Increased	☐ Decreased	☐ No Change
Sleep Pattern	☐ Difficulty falling asleep	☐ Falls asleep early in PM	☐ Sleeps too late
	☐ Awakens during night	☐ Awakens too early in AM	☐ No Problem
	Is the sleep pattern new?	☐ Yes ☐ No	
Average sleeping time	Hours	Average awake time?	Hours
CPAP machine?	☐ Yes ☐ No		
Urinary Incontinence	☐ Yes ☐ No	Is this a new issue?	☐ Yes ☐ No
Fecal Incontinence	☐ Yes ☐ No	Is this a new issue?	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Is this a new issue?	☐ Yes ☐ No
Sexual Interest	☐ Increased	☐ Decreased	☐ No Change
Sexual Activity	☐ Increased	☐ Decreased	☐ No Change
Menses (women only)	Dates of last two cycles:		
	Usual cycle length:	Days	Usual days of flow: Days
	Typical: ☐ regular ☐ irregular ☐ heavy ☐ light ☐ painful ☐ not a problem		
	Menstrual flow: ☐ heavy ☐ moderate ☐ light		
Menopausal	☐ Yes ☐ No	Recent Onset?	☐ Yes ☐ No
Smoke	☐ Yes ☐ No	☐ Increased ☐ Decreased ☐ No Change	
Alcohol Use	☐ Yes ☐ No	☐ Increased ☐ Decreased ☐ No Change	
Abuse Alcohol or Drugs	☐ Yes ☐ No	Drug of choice, if applicable:	

Please explain the onset of any new issues or any changes of behavior, as noted above:

C. Current & Past Treatment Summary (attach additional information, if available):

Current Psychological, Behavioral or Substance Abuse Treatments	☐ Yes ☐ No If yes, summarize below:
Treatment Reason(s):	
Treatment Methods or Modalities:	
Where:	
Outcome or Progress:	
What is the evidence for success and/or failure of these treatments?	

Past Psychological, Behavioral or Substance Abuse Treatments	☐ Yes ☐ No If yes, summarize below:
Treatment Reason(s):	
Treatment Methods or Modalities:	
Where:	

Outcome or Progress:	
What is the evidence for success and/or failure of these treatments?	

D. Current Medication (Attach additional medication information if necessary. Attach MAR, if applicable.)

Medication	Diagnosis/ Reason for medication	Dosage	Schedule	Compliant	Side Effects Experienced	Prescribing Doctor	Date Started
				☐ Y ☐ N			
				☐ Y ☐ N			
				☐ Y ☐ N			

E. Previous Medication Trials:

Medication	Diagnosis/ Reason for medication	Dosage	Prescribing Doctor	Date Discontinued	Reason for Discontinuation of Medication

F. Medication, Food, Environmental, or Other Allergies:

☐ No Known Allergies (NKA) ☐ No Known Drug Allergies (NKDA) ☐ Latex Allergy ☐ Yes ☐ No

Medication/ Drug Allergy & Significant Reaction History: ☐ Yes ☐ No (If yes, describe & indicate dates/ year)

Medication	Allergic Reaction	Date/ Year

Food and Other Allergies & Significant Reaction History: ☐ Yes ☐ No (If yes, describe & indicate dates/ year)

Food & Other	Allergic Reaction	Date/ Year

Seasonal Allergies & Significant Reaction History: ☐ Yes ☐ No (If yes, describe & indicate dates/ year)

Seasonal	Allergic Reaction	Date/ Year

II. DIAGNOSIS AND MEDICAL HISTORY

A. DSM-IV Diagnoses

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

B. Current Diet:

Food Consistency: ☐ Regular ☐ Pureed ☐ Soft ☐ Chopped ☐Other (Describe)

History of Choking Episodes: ☐ yes ☐ no

C. Other Medical Issues or Diagnoses:

1. Heart problems or congenital heart defect: ☐ Yes ☐ No

If yes, does the person require antibiotics prior to dental work? ☐ Yes ☐ No

2. Asthma: ☐ Yes ☐ No

If yes, does the person use an inhaler? ☐ Yes ☐ No

Does the person take oral medications to control asthma ☐ Yes ☐ No

When was the last asthma attack? ☐ Yes ☐ No

3. Diabetes: ☐ Yes ☐ No

If yes: ☐ Type I (Insulin Dependent) ☐ Type II (Non-Insulin Dependent) ☐ Gestational

Does the person take oral medications to control diabetes? ☐ Yes ☐ No

Does the person receive insulin injections? ☐ Yes ☐ No

Can the person self-administer insulin injections? ☐ Yes ☐ No

Is the person currently on a sliding scale insulin? ☐ Yes ☐ No

4. High Blood Pressure: ☐ Yes ☐ No

5. Seizure Disorder: ☐ Yes ☐ No

When was the last seizure? _____

How many seizures has the person had in the last month? _____

How long do the seizures typically last? _____

Is the person currently followed by a neurologist? ☐ Yes ☐ No

Does the person have a "PRN" medication for seizure activity? ☐ Yes ☐ No

PRN medications for seizures must have specific written guidelines from the physician.

5. High Cholesterol: ☐ Yes ☐ No

6. Kidney Problems: ☐ Yes ☐ No

7. History of Urinary Tract Infections: ☐ Yes ☐ No Date of last UTI: _____

8. History of MRSA infection: ☐ Yes ☐ No

Date of MRSA infection: _____

Location of MRSA infection: _____

9. Does the person currently have an open skin wounds or lesions? ☐ Yes ☐ No

10. Bleeding Problems: ☐ Yes ☐ No

11. Cystic Fibrosis: ☐ Yes ☐ No

12. Head or spinal cord injury: ☐ Yes ☐ No

If yes, when did the injury occur? _____

If yes, Please provide specifics regarding type of injury and how it occurred? _____

13. Multiple Sclerosis: ☐ Yes ☐ No

14. Spina Bifida: ☐ Yes ☐ No

15. Muscular Dystrophy: ☐ Yes ☐ No

16. Orthopedic Impairment: ☐ Yes ☐ No

17. Cerebrovascular Disease: ☐ Yes ☐ No

18. Parkinson Disease: ☐ Yes ☐ No

19. Huntington's Disease: ☐ Yes ☐ No

20. Hyperthyroidism: ☐ Yes ☐ No

21. Hypothyroidism: ☐ Yes ☐ No

22. vitamin B12 deficiency: ☐ Yes ☐ No

23. History of Migraine Headaches: ☐ Yes ☐ No

24. GERD/Acid Reflux ☐ Yes ☐ No

25. Dental Problems ☐ Yes ☐ No

Date of last migraine: _____ What triggers the migraine? _____

D. Immunizations:

Tuberculin Skin Test: _____ (Date) ☐ Negative ☐ Positive

If positive, must have a chest x-ray or screening by the local health department prior to admission:

TB Screening:

Has the person exhibited any of the following signs or symptoms?

1. Unexplained productive cough lasting greater than 3 weeks in duration: ☐ Yes ☐ No

2. Unexplained fever: ☐ Yes ☐ No

3. Night sweats: ☐ Yes ☐ No

4. Shortness of breath/chest pain (persistently having shortness of breath or chest pain): ☐ Yes ☐ No

5. Unexplained weight loss or loss of appetite: ☐ Yes ☐ No

6. Unexplained fatigue: ☐ Yes ☐ No

Tetanus Injection:

Date of last tetanus injection: _____

Influenza Vaccination/Screening:

Date of seasonal flu vaccination: _____

Date of H1N1 vaccination: _____

Does the person have any signs or symptoms of the flu? ☐ Yes ☐ No

Does the person have a fever currently or within the last 48 hours? ☐ Yes ☐ No

Hepatitis B Vaccination

E. Other Disabilities:

☐ Autism Spectrum ☐ Cerebral Palsy ☐ Blind ☐ Deaf ☐ Hard of Hearing ☐ Fragile X ☐ Prader-Willi

☐ Speech/ Communication ☐ Substance Abuse ☐ Traumatic Brain Injury ☐ Vision Impairment

☐ Undetermined ☐ Other (please indicate):

F. General Physical Description

Height:	Weight:	Hair Color:	Eye Color:
Please describe any other unique physical characteristics (i.e. tattoos, scars, skin complexion, etc.):			

G. Etiology (Cause) of Mental Retardation:

☐ Down Syndrome ☐ Environmental Exposure ☐ Fetal Alcohol Syndrome ☐ Fragile X ☐ Hydrocephalus

☐ Infectious Disease ☐ Prenatal Infection ☐ Stroke ☐ Traumatic Brain Injury ☐ Undetermined

☐ Other (please indicate):

H. Cognitive Disability Functioning:

Area	Level	Test(s) Performed	Test(s) Date	Result(s)	Report Available?
Cognitive IQ					☐ Yes ☐ No
					☐ Yes ☐ No

Adaptive					☐ Yes ☐ No
					☐ Yes ☐ No

*Please attach any available reports and/or documentation from additional reports performed.

I. Sensory & Physical Functioning:

Area	Impairment	Issue Description Include Acute Sensitivities – Sight, Sound, Tactile, Environmental, etc.	Equipment
Hearing	☐ Yes ☐ No		
Vision	☐ Yes ☐ No		
Tactile	☐ Yes ☐ No		
Communication			
Ambulation			
Other	☐ ☐ ☐		

J. Basic Skills – Level of Assistance

Skill	No Prompt	Verbal Prompt	Gestured Prompt	Partial Assist	Full Assist	Description
Mobility	☐	☐	☐	☐	☐	
Eating & Drinking	☐	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	☐	
Toileting (Urine)	☐	☐	☐	☐	☐	

Toileting (Feces)	☐	☐	☐	☐	☐	
Menstruation	☐	☐	☐	☐	☐	
Bathing (Shower)	☐	☐	☐	☐	☐	
Bathing (Bath)	☐	☐	☐	☐	☐	
Fire Evacuation	☐	☐	☐	☐	☐	
Telephone Use	☐	☐	☐	☐	☐	
Money Skills	☐	☐	☐	☐	☐	

K. Developmental History & Biopsychosocial Timeline (Attach additional information if needed.)

Stage	Major Issues?	Description of Significant Factors or Issues	Dates/ Yr (approx.)
Prenatal Development & Birth	☐ Yes ☐ No		
Childhood Development, Behavioral and/or Medical	☐ Yes ☐ No		
Puberty & Adolescent Development, Behavioral and/or Medical	☐ Yes ☐ No		
Adult Behavioral and/or Medical	☐ Yes ☐ No		

L. Family Medical History

Document family history of medical, neurological, psychiatric, and developmental conditions. Note such occurrences as overt symptomology, suicide attempts and completions, substance abuse, psychiatric hospitalizations, and any other psychological or behavioral treatments.

Relative	Description
☐ Father	
☐ Mother	
☐ Brother	
☐ Sister	
☐ Grandfather ☐ Maternal ☐ Paternal	
☐ Grandmother ☐ Maternal ☐ Paternal	
☐ Other (identify):	

Additional Information:

M. Hospitalization and Developmental Center Admission History (Attach additional information, if needed.)

Psychiatric or Substance Abuse Hospitalizations

Hospital & Location	Primary Reason	Involuntary?	Dates	Discharge Summary Avail?
1.		☐Yes ☐No		☐Yes ☐No
2.		☐Yes ☐No		☐Yes ☐No
3.		☐Yes ☐No		☐Yes ☐No
4.		☐Yes ☐No		☐Yes ☐No

Other Medical or Surgical Hospitalizations

Hospital & Location	Primary Reason	Dates	Discharge Summary Avail?

1.			☐Yes ☐No
2.			☐Yes ☐No
3.			☐Yes ☐No
4.			☐Yes ☐No

Developmental Center Admissions

Center & Location	Primary Reason	Involuntary?	Dates	Discharge Summary Avail?
1.		☐Yes ☐No		☐Yes ☐No
2.		☐Yes ☐No		☐Yes ☐No
3.		☐Yes ☐No		☐Yes ☐No
4.		☐Yes ☐No		☐Yes ☐No

N. Primary Care Physician and Psychiatrist

Doctor	Location	Date of Recent Visit	Visit Frequency	Notes Available?
Primary:				☐Yes ☐No
Psychiatrist:				☐Yes ☐No

O. Specialty Consultations (Include Ind. & Family Therapies and Dental)

Name	Specialty	Location	Date of Recent Visit	Report/ Notes Available?
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

P. Lab and Medical Test Results

Test	Facility	Results	Date	Report Available?
Blood Tests				☐Yes ☐No
EEG				☐Yes ☐No
Imaging				☐Yes ☐No
Other:				☐Yes ☐No

Additional Information:

III. NATURAL SUPPORTS, ACTIVITIES, & HABILITATIVE SERVICES

For each section please describe, note changes, dates, and especially any systemic responses to the problem(s) which resulted in this referral.

Current Living Situation:

☐ Community ICF/MR ☐ Supervised Group Living ☐ Supported Living

☐ Foster Care Home ☐ AFL ☐ Independent/ <6 hours support

☐ Homeless, Shelter ☐ Homeless, Unsheltered ☐ Other:

☐ Family, list with whom:

Provider, if applicable:	Living Since: / (mm/yy est.)
Describe:	

Factor	Changes?	Describe	Dates
Moves	☐Yes ☐No		
Losses	☐Yes ☐No		
Staff Changes	☐Yes ☐No		
Housemates	☐Yes ☐No		

Other	☐Yes ☐No		
Prev. Living Situation	☐Yes ☐No		

Spends most time with:	
☐ Family:	☐ Housemate:
☐ Friend(s):	☐ Support Worker:

Educational Activity:

☐ High School Full Mainstream ☐ High School Partial Mainstream

☐ High School Segregated Class ☐ Compensatory Education ☐ Traditional College

☐ Non-traditional College ☐ None

☐Other:

School:	Enrolled Since: / (mm/yy est.)
Describe:	

Factor	Change?	Describe	Date
School or Classroom	☐Yes ☐No		
Teacher(s)	☐Yes ☐No		
Other	☐Yes ☐No		
Previous Educational Activities	☐Yes ☐No		

Vocational Activity (✓ all that apply):

☐ Full Time Job ☐ Part Time Job ☐ Workshop ☐ Pre-Work Training

☐ Volunteering ☐ Job Coach ☐ None

Activity:	Engaged Since: / (mm/yy est.)
Activity:	Engaged Since: / (mm/yy est.)
Describe:	

Factor	Change?	Describe	Date
Loss of Job	☐Yes ☐No		
Co-Worker	☐Yes ☐No		
Job Coach	☐Yes ☐No		
Other	☐Yes ☐No		
Previous Work Situation(s)	☐Yes ☐No		

Community Activity (✓ all that apply):

☐ Day Program ☐ Special Population Recreation ☐ Inclusive/ Mainstream Recreation

☐ Clubs/ Support Groups ☐ Faith-Based Group ☐ Informal Activities with Family or Friends

☐Individual Interest Pursuit ☐ None

☐ Participates with assistance from: ☐ Family ☐ Friend(s) ☐ Support Workers

Activity:	Since: / (mm/yy Est.)
Activity:	Since: / (mm/yy Est.)
Activity:	Since: / (mm/yy

	Est.)

Factor	Change?	Describe	Date
Activity Ceased	☐Yes ☐No		
Leader/ Instructor Changes	☐Yes ☐No		
Support Worker Changes	☐Yes ☐No		
Co-Participant Changes	☐Yes ☐No		
Other	☐Yes ☐No		
Previous Activities	☐Yes ☐No		

Additional Comments:

IV. HISTORY OF BEHAVIORAL STRENGTHS & CHALLENGES

(Including criminal/ court activity & other target issues)

A. Strengths, Motivations, and Likes Assessment

Describe the strengths of the individual. Include in what activities he/she excels, personal strengths, interpersonal strengths. Whenever possible, be very behaviorally specific:
Describe what motivates the individual. Include anything that motivates the individual, especially those that he/she describes. Please be very specific.
Describe the general likes of the individual. Include anything the person likes (i.e. people, places, things, colors, activities, community events, etc.):

B. Criminal and/or Court Involvement – include all charges regardless of disposition (Include all youth and adult involvement):

☐ Probation ☐ Parole ☐ None ☐ Other:

Date (Est.)	Criminal Charge	Outcome/ Disposition
/		
/		
/		

C. Other Target Issues:

Respects own clothing and property: ☐ Yes ☐ No

If No, describe including frequency (hourly, daily, weekly, monthly…):

Respects others' property: ☐ Yes ☐ No

If No, describe including frequency (hourly, daily, weekly, monthly…):

Adheres to Rules and Regulations: ☐ Yes ☐ No

If No, describe including frequency (hourly, daily, weekly, monthly…):

Sexual Behavior: ☐ Appropriate ☐ Inappropriate

If inappropriate, describe including frequency (hourly, daily, weekly, monthly…):

Temper: ☐ Appropriate ☐ Verbally Aggressive ☐ Physically Aggressive

Describe including frequency (hourly, daily, weekly, monthly…):

Sleep Habits:

Describe any issues:

Restaurant Behavior: ☐ Appropriate ☐ Inappropriate

If inappropriate, describe including frequency (hourly, daily, weekly, monthly…):

Car Behavior: ☐ Appropriate ☐ Inappropriate

If inappropriate, describe including frequency (hourly, daily, weekly, monthly…):

Movies: ☐ Appropriate ☐ Inappropriate

If inappropriate, describe including frequency (hourly, daily, weekly, monthly…):

Stores, Malls, Crowds: ☐ Appropriate ☐ Inappropriate

If inappropriate, describe including frequency (hourly, daily, weekly, monthly…):

Picks up objects and places in mouth/ swallows: ☐ Yes ☐ No

If Yes, describe including frequency (hourly, daily, weekly, monthly…):

Leaves home or area without notification: ☐ Yes ☐ No

If Yes, describe including frequency (hourly, daily, weekly, monthly…):

Additional Information:

V. OTHER INFORMATION: RESPITE SERVICES

Is Individual Eligible for Respite Services? ☐ Yes ☐ No ☐ Planned ☐ Crisis

* (If eligible for respite, either planned or crisis, complete section V. If not eligible, go directly to section VI.)*

A. <u>Socialization Skills:</u>

Describe socialization skills/ style with each of the following (i.e. appropriate, talkative, quiet, assertive, etc.):

Family:
Friends/ Peers:
Staff:
Strangers:

B. Daily Routine/ Preferences:

Describe a typical day in the individual's life, including preferences and abilities:

A.M. Routine:
P.M. Routine:
Favorite Activities:
Strong Likes/ Dislikes:

C. Visitation/ Independence:

1. Approved Contacts (List phone numbers and any visitation limitations):

Contact	Phone Number	Limitations
	- -	
	- -	
	- -	

2. Is there anyone with whom this individual may leave during the time at the Respite Home?

Contact	Phone Number	Limitations
	- -	
	- -	
	- -	

3. Is the individual able to have unsupervised time? ☐ Yes ☐ No

Are there any limits to unsupervised time? ☐ Yes ☐ No Describe:

VI. CONSULTATION QUESTIONS:

Please indicate any particular questions that you would like to have answered as a result of this consultation/ evaluation:

Please note anything else that may help us to better understand and appreciate this person's situation and/ or problem(s):

Disposition Recommendations:

VII. SUMMARY AND RECOMMENDATIONS

Summary and Impressions:

Recommendations	Description
☐ Additional Assessments	
☐ Suggested Targeted Behavior/ Symptom Monitoring	
☐ Psychosocial/ Residential/ Day Services modifications (describe recommended individual habilitation plan)	

☐ Other (Identify):	
☐ Other (Identify):	
☐ Other (Identify):	

VIII. SOURCES OF INFORMATION

A. Individual Interviews

Name	Program/ Organization (if any)	Relationship	Date
1.			/ /
2.			/ /
3.			/ /
4.			/ /
5.			/ /
6.			/ /

B. Records Reviewed

Record Source	Description	Date
		/ /
		/ /
		/ /
		/ /
		/ /

		/ /

C. Other

Record Source	Description	Date
		/ /
		/ /
		/ /
		/ /
		/ /
		/ /

D. Additional Sources What other agencies or supports should be included in record requests? Where and from whom has the individual received supports that is not included in this intake?

Record Source	Description	Date
		/ /
		/ /
		/ /
		/ /
		/ /
		/ /

Signatures:

_____ _____

Individual's Signature Date

_____ _____

Legally Responsible Person Signature (if applicable) Date

_____ _____

QP/ Clinician Signature Date

_____ _____

Clinical Home Signature Date

_____ _____

Nurse Signature Date

Attachment IV

NC-START Respite
Admission and Discharge Summary

Region: East Central West START QP:

Location of respite program:
Guest name:
Date of Admission:
Date of Discharge:

Primary contact/caregiver: name, address and phone number:

Diagnosis at Admission:

Axis I
Axis II
Axis III
Axis IV
Axis V

Medications at Admission:

Medication	Dose	Frequency

Physical Health/Medical Concerns at Admission:
Type of admission: Crisis Respite Planned Respite

Date and Reason for any Previous Admissions (Planned and Crisis):
Chief complaint/Purpose of Admission:

Goals at Admission (List up to three Goals for Respite Stay)Goal 1: Objectives to meet goals (include assessments, activities, interventions, data collection, etc.)
A)
B)
C)
Goal 2: Objectives to meet goals (include assessments, activities, interventions, data collection, etc.)
A)
B)
C)
Goal 3: *(family education)*Objectives to meet goals (include assessments, activities, interventions, data collection, etc.)
A)
B)
C)

Measures of discharge readiness:
1.
2.
3.

Estimated discharge date (According to goals/objectives):

Services Requested During Respite Stay:

- Assessments (Attach Copy)
- Medical Assessments (Attach Copy)
- Crisis Plan Developed/Modified?(Attach Copy)
- Changes in Treatment or Treatment Plan?
- Medication modification?
- Medical Supports Modified?
- Family Support or Education Provided?
- Consultation with NC START Clinical Director/Psychologist?
- Consultation with NC START Medical Director/Psychiatrist?

Describe:

Services provided During Respite Stay:

- Assessments (Attach Copy)
- Medical Assessments (Attach Copy)
- Crisis Plan Developed/Modified?(Attach Copy)
- Changes in Treatment or Treatment Plan?
- Medication modification?
- Medical Supports Modified?
- Family Support or Education Provided?
- Consultation with NC START Clinical Director/Psychologist?
- Consultation with NC START Medical Director/Psychiatrist

Describe: **Communication Plan** (Primary contact, how will information be shared). *List names, roles and responsibilities, schedule of contacts:*

Diagnosis at Discharge (if changed during visit)

Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	

Medications at Discharge (if changed during visit)

Medication	Dose	Frequency

Data collected and reviewed during respite stay: (Behavioral Support Data Sheet; Sleep Activity, Eating, Toileting, Adaptive Functioning/ Activity Level; other)
Attach data analysis

Summarize findings:

Describe level of activity and participation while at START Respite:Presentation at time of discharge/outcomes/ recommendations: (Include recommended activities routine and follow-up assessments needed as well as what did we learn that would help to prevent future admissions to emergency respite and the hospital?)

Discharge Meeting Summary (what was discussed during meeting and who is responsible for ensuring the activities take place)

New interests/skills developed in Respite: Follow-up scheduled?

Visit to respite? Date and time:

Team Meeting with START clinician Date and time:

Home visit? Date and time:

Team Signatures (collected at admission):

Name/Position: _____

Signature/Date: _____

Name/Position: _____

Signature/Date: _____

Name/Position: _____

Signature/Date: _____

Team Signatures (collected at discharge):

Name/Position: _____

Signature/Date: _____

Name/Position: _____

Signature/Date: _____

Name/Position: _____

Signature/Date: _____